

Multicultural competency in substance abuse treatment

The differences that make a difference

-The case of Norway

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SUMMARY

Norway has become a multicultural society with an ever increasing global interdependence. With the increasing complexity and interdependence of economic, political and social affairs, similarities and differences among cultural groups are more evident. The substance abuse care services are multileveled and complex, with different service providers offering similar services in different setups. In addition, these services appear to have been tailored to suit the ethnic majority and are to some extent not culturally responsive to the needs of the ethnic minority clients. It is, therefore, becoming a challenge to assume that mainstream therapeutic treatment services will be applicable to the ethnic minority, unless it culturally adapted. Clients have a right to access individually tailored treatment based on the client's needs and situation. A single national treatment intervention is no longer acceptable as a viable concept for the treatment process. Norwegian treatment programmes and clinical practices should reflect aspects of diversity in order to meet the unique and distinct therapeutic needs of each ethnic minority client.

When the discussions of cultural competency arise; the question often asked is how does one become culturally competent? How can a therapist provide culturally competent interventions that can lead to a successful outcome? The findings indicate that applying culturally sensitive interventions in various stages of therapy, can offer an opportunity for the client and the therapist to deconstruct the hindering cultural constructions and reconstruct new and common realities. Culturally sensitive interventions, allows the therapist to acknowledge the client's experience and worldview, and opens up possibilities for change according to the client's goals. However, means to integrate cultural issues in each stage of counseling is virtually missing. In the context of a therapeutic relationship, the study suggests that the therapist should develop a position that interacts with the values, beliefs, experiences, responses and ideas of the client; and together they construct culturally sensitive therapeutic realities and solutions. As such, no psychotherapeutic treatment orientation could be more appropriate and legitimate than one that is multicultural, one that involves client's own contribution.

This thesis attempted to investigate the application of social constructionist approaches in therapy. The major aim was to find out the qualitative effects of involving ethnic minorities' own needs and contribution in psychotherapy. Semi-structured interviews with psychologists and ethnic minority clients formed the main source of data for this study

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CHAPTER ONE

1.0 INTRODUCTION

Effective clinical practice must have the flexibility and breadth to embrace the diversity of clients who seek treatment. The fact that people within a society may not have a shared history, culture and language poses new challenges in the way we organize and execute treatment strategies in the society. In the city of Oslo, cultures are as dissimilar as the 200 countries or so from which they come from; and by the year 2010, Norway had 600 religious and philosophical denominations to which different members ascribe and to which they exclude each other, and as varied as their geographical and biological histories. Patterns of alcohol and substance abuse vary markedly between groups. Therefore, cultural diversity compels therapists to be aware of cultural factors in order to engage in some culturally sensitive interventions. Professional therapists have an obligation to understand the framework of the client, acknowledge and discuss the differences and similarities in a way that the client is likely to be able to understand and accept (Kale & Tonje 2011, Regjeringen 2010).

The conventional approach to counseling and psychotherapy is anchored in Eurocentric values. These values are not necessarily congruent with those held by all clients seeking help. As a result, there may be significant value discrepancies between therapists and clients; where on one side clients are unique and the psychosocial unit of operation is the individuals; while on the other side, a client is a client, and the goals and techniques of counseling and therapy are equally applicable across all groups. The knowledge base learnt in school springs from western cultural values; schools are seldom required to teach about working with minorities, but in the real world, therapists must work with all citizens regardless of ethnicity or nationality. As a result, therapists will inevitably encounter clients that differ from them in terms of beliefs, norms and values; this requires cross-cultural understanding, and it is desirable that multicultural skills should start with reflections on the significance of approaches, theories and methods. Such approaches should include cultural competency, sensitivity, and should reflect on how cultural differences and minority positions can color meetings and communication with clients (Holm 2000, Sue & Sue 2008).

Cultural deficiency in a culturally insensitive setting, may lead to wrong assessments and, diagnoses and unsatisfactory treatment of culturally diverse clients. Ignoring the influence of

a client's cultural or ethnic identity diminishes the effectiveness of treatment. Therefore, cultural competency should become a framework for understanding reality and establishing values, beliefs and behaviors that shape the therapeutic processes when the therapists work with people who are culturally “other.” Crossing the bridge to the otherness allows for the recognition of similarities and differences. It is important to gain culturally specific knowledge in order to meet clients where they are, rather than making them fit with the therapist’s lifestyle and worldviews. Nonetheless, exposure to people and settings not previously a part of the therapist’s reality is central to providing culturally sensitive therapy. This can be challenging because often individuals who require care in these settings are particularly vulnerable. Hence, carefully planned orientation and thoughtfully designed treatment strategies are vital to facilitate success and satisfaction among ethnic minorities with drug addiction problems (Leach & Aten, 2010).

This study aims at providing the reader with some introduction to the debates on multicultural competency, multicultural understanding of the minority client, and inclusion of the client’s thoughts and ideas that is as valuable as for the therapist’s; where the client is given an opportunity to influence and the ability to evaluate the various treatment options suitable for him in the therapeutic process.

1.1 Relevance of the study

This study has first and foremost sprung from personal motivation. I come from a developing country where the problem of immigration and substance abuse are taking root. According to Elster and Skog (1999) on a practical level substance abuse causes dire consequences; ravaging lives and communities, among other societal tribulations, such as poverty, HIV aids and joblessness, and on a theoretical level substance abuse creates the paradox of voluntary self-destructive behavior. For that reason, the objective of this thesis is to investigate the assumptions that the needs and contributions of substance users from minority groups are not well integrated in the mainstream treatment strategies that are sometimes ethnically and culturally insensitive.

In the case of Norway, the study will hopefully contribute to increasing substance abuse treatment options for ethnic minority populations, identify barriers and guide therapist as well as clients to enter and complete psychotherapy treatment. It is my hope that this thesis will inspire therapists to undertake the task of developing cultural competency; not only will they

enhance their ability to help others; they will also enrich themselves in the process. The study can be of broader interest to all persons who work in a multicultural setup. I also hope the study will contribute to a better understanding of multicultural elements in the various complex substance abuse treatments modalities.

1.2 Presentation of the research question

The main goal of this thesis is to discuss theoretical, conceptual research and practice issues related to multicultural counseling/therapy and cultural competency. My aim is to provide empirical data that can answer the research question based on relevant theories. By reviewing and exploring the empirical data I will try to answer the following question,

How can better multicultural understanding of minorities, their needs and their own contributions in psychotherapy, lead to a good therapeutic process? – The case of Norway.

Through the discussion of issues and views raised by the informants, this thesis will broaden the umbrella of multiculturalism and enlighten the main theme of the thesis.

1.3 Background of the study -My pre-understanding

In the summer of 2007, I got a job as a part time employee in a rehabilitation center for substance users in Oslo. This was my first close encounter with substance users. My main responsibility was to help and engage clients in practical issues and recreational activities in and outside the institution. I accompanied them to some official errands. As a result, I became aware of the challenges most of them met in the social offices. In the meantime, I had the opportunity to speak with some of the clients about their experiences with treatment and what expectations they had. I asked them about the treatment strategies and so on.

Through my work, as a social worker in a care facility under the Oslo municipality, where I still work; I have come to experience that, among counselors/therapists, there is a widespread perception that clients from minority groups can be difficult and require special expertise. This can result in a number of therapists opting out of contact with minority clients or choosing ethnic Norwegian clients as their main clients; this could indicate a lack of multicultural competency or presence of biases. In light of this, it is my wish to illustrate how therapists could be more able to meet ethnic minority clients where they are in order to understand clients through their culture and in a meaningful approach. Indeed, Arksey and

knight (1999:154) assert that “the literature is one of the sources of preconceptions that we bring to the design of a study and to the analysis of the data”. Accordingly, preconceptions in this study are informed by the personal and professional experiences and the motivation for doing it. Therefore, analysis, discussion and conclusion will be constructed in the light of literature reviewed, empirical material, personal and professional experience.

1.4 Definition of terms

The following are the working definitions of the terms relevant in this study.

1.4.1 Client

In my thesis, I use the term "client" to refer to people from ethnic minorities who have substance abuse problems that have requested or are receiving services from treatment facilities/or any other form of clinical help. My approach is informed by Ulvestad (2007:23-34), who argues that “names or designations used in health fraternity can be crucial in relation to how individuals think about themselves when meeting with the care givers”. These designations can open doors, but can create barriers too. The use of the client designation is crucial because, as a client, it is expected that the one offering services listens and pays attention to the user’s viewpoints. However, although I denote clients with ethnic minorities as a group, this must not be understood as a homogenous group.

1.4.2 Ethnic minority and culture

According to Gordon (1994:23) “culture is sometimes used to describe the universal qualities that all people possess which distinguish them from other species or the unique dimensions by which a particular human culture is described”. He further describes culture “as the specific ways of thinking, feeling and acting, distinguishing one group from another”. Included in the definition of culture are the elements of knowledge, art, beliefs and customs that are recognized as significant determinants of the behavior and values of members of an ethnic group.

In this report, the term *ethnic minority* is used to designate persons because of the external features or appearance (for example, dark skin) and/or linguistic, cultural or religious background or heritage that differ significantly from the ethnic majority. Eriksen & Sajjad (2011:77) allege that “there are two types of ethnic minorities in Norway; Indigenous or Sami and urban minorities, (immigrants, refugees and their children and grandchildren)”. In this

thesis, I use the concept of urban minorities. Thorbjørnsrud (2001) maintains that the terms minority and the majority are usually applied in relation to numerical inferiority and superiority. She points out that a group with a large number of inhabitants constitutes the majority while the group with a smaller number is the minority. The terms can also be used to describe or define the relationship between groups (Kuvoame 2005).

Eriksen & Sajjad (2011:77) have pointed that “the concepts of minority and relative majority, are about relationships rather than things; a minority exists only in relation to a majority and vice versa”. On the other hand, the relationship between minority and the majority is defined based on the groups' different access to power and resources; the majority determines the rules and access to resources. Yet, minority's and majority's power inequity can lead to unequal access to scarce resources or other social benefits. This can affect minority's participation and may result in marginalization or exclusion from society (Kuvoame 2005). Thorbjørnsrud (2001) asserts that the majority has the power to define who the minority groups are. Majority can more or less define the framework for interaction with minority groups and thus minority groups must interact on their terms. This means that it is the majority's values, norms, ways of life and ways of thinking that permeates society's economic, social, cultural and political processes.

1.4.3 Substance abuse/dependence

According to Beck et al. (1993:2), the diagnostic and statistical manual of mental disorders (DSM-III-R) “distinguishes between substance abuse and dependence. Abuse is defined as a maladaptive pattern of psychoactive substance use while dependence (considered more serious than abuse) is defined as “impaired control of use” (i.e., Physiological addiction). In the present thesis, emphasize is not on these distinctions. Instead, I will view any pattern of psychoactive substance use as problematic and requiring intervention if it results in adverse social, vocational, legal, medical or interpersonal consequences, regardless of whether the user experiences physiological tolerance and withdrawal or not.

1.4.4 Multiculturalism

Camino (1995) alleges that, “Multiculturalism is a theory that can incorporate the strengths, potentials, and the diverse/multicultural realities of all people regardless of age, race, class, and gender. Indeed, Onyekwuluje (2000:69) says that “multiculturalism is the mastered knowledge and skills needed to feel comfortable and communicate effectively with people of

all cultures and in all cross-cultural situations”. Likewise, O’Grady (2000) maintains that multiculturalism as a “perspective and reality that there are many different cultures and subcultures in the world that need to be recognized, valued and understood for their differences and similarities”.

1.4.5 Multicultural counseling and therapy

Sue & Torino (2005:42) define multicultural counseling as “...both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, recognizes client identities to include individual, group, and universal dimensions, advocates the use of universal and culture-specific strategies and roles in the healing process and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of clients and client systems”.

1.4.6 Cultural competence

Sue & Torino (2005:8) states that, “Cultural competency is the ability to engage in actions or create conditions that maximize the optimal development of client and client systems. Multicultural counseling competence is defined as the counselor’s acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse background), and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups”.

Likewise, Cross et.al (1989:13) defines Cultural competence as, “The integration and transformation of knowledge about individuals and groups of people into specific standards, policies, behaviors, knowledge, attitudes and practices that come together in a system, organization, or among professionals that enables, recognizes and responds effectively to the needs of culturally diverse populations in cross-cultural situations in order to increase the quality of services, thereby producing better outcomes”.

These active definitions set an operational framework for establishing multiculturalism counseling and cultural competence in this thesis.

CHAPTER TWO

2.0 RESEARCH METHODS AND METHODOLOGY

This chapter presents the material and methods used in gathering information for the study.

2.1 Design of the study

The choice of methodology was determined by the nature of the research in question. It defined the methodical standpoint from which the problem would be approached. The research objective as outlined in Chapter one suggested that my research would depend on interviews as the source of qualitative data while a literature review would constitute the theoretical and comparative framework of the study. I settled on qualitative research method because I wanted to explore meanings of social phenomena as experienced by individuals themselves, in their natural context through systematic data collection. I considered the best way of accessing these data from a few respondents was to use qualitative research method as described by Malterud (2001:483); she writes that qualitative research methods involves the systematic collection, organization, and interpretation of textual materials derived from talk or observation.

2.2 Qualitative research interviews

This thesis involved the collection of data elicited primarily from the interviewees. The interviews were recorded and later on transcribed in order to allow for analysis of the informants' words and commentaries. Arksey & Knight (1999) assert that in, social science, people's perceptions of the world are more or less individualistic and that different interviewing approaches are suitable for documenting perceptions that are widely shared from those used when exploring more personal, individualistic understandings. I opted for the qualitative interviewing in order to explore people's understandings, perceptions, and feelings and in order to concentrate on the distinctive features of situations and events, and upon the beliefs of individuals or sub-cultures.

Through the interviews, informants were offered the opportunity to give detailed accounts of their stories, beliefs, feelings and actions, and the researcher listened attentively to these. I explored the construction and interpretation of meaning in relation to the research subject. The interview process was in line with a question guide, laid out in a semi-structured manner with open-ended questions. The use of semi-structured interviews in collecting information

was intended to engage with the interviewees by posing questions in a neutral manner. I listened attentively and asked follow-up questions, and asked for clarification where necessary during the interview process. In addition, semi-structured interviews focused on uncovering new clues, open new dimensions of a problem and secure vivid and accurate inclusive accounts based on personal experience.

2.3 Sampling methods, participant selection and profile

2.3.1 Sampling methods

The intention of the research study was a central factor that guided the selection of the sampling methods and the informants. I adopted the strategic sampling technique to recruit elite informants and thereafter snowball sampling method to recruit the client informants. I strategically selected informants likely to assist in exploration of the themes in this thesis, informants that I recognized to be potentially informative in terms of their competence and ability to inform the study. Indeed, Malterud (2003) describes a strategic sample of informants as being picked on the basis of the knowledge that one possesses. She argues that in qualitative research, the mode of data collection is not driven by the principle of sample representativeness, but rather on the notion of who can shed light on the questions being investigated. For that reason, I sent a request to institutional leaders asking them to help me identify elite informants that suited my criteria. Thereafter, I used a snowball sampling method for identifying client informants from my initial contact with a client that was recruited by one of the elite informant. The first client informant was at the end of the interview requested to identify or recommend other individuals to be sampled. Information was collected from those identified and, in turn, those identified became a basis of further data collection.

Creswell (2005) describes snowball sampling as a form of purposive sampling that typically proceeds after a study begins and occurs when the researcher asks participants to recommend other samples to be sampled. This method is good in sampling population that is hard to reach or contact. According to (Kumar 2011) this method involves individuals recruiting other individuals to take part in a research; there may be shared social factors and traits between those individuals that could help to break down some of the barriers that prevent such individuals from taking part. This could include populations that are marginalized, social stigmatized, as well substance users.

2.3.2 Elite informants

All the informants met the selection criteria. The employees were chosen because they have concentrated and varied experience that illustrate and form the basis for their understanding, interpretations and attitude towards ethnic minority clients. Those who participated in the interviews had all been working with substance users with ethnic minority backgrounds. In addition, they were working in institutions that cater for diverse needs of substance users, such as mental health and substance abuse problems while some were working directly with initiatives that have substance abuse as their main activity. In total 9 elite informants were interviewed, 7 women and 2 men, from four different institutions, they were predominantly Norwegians. In some cases, I interviewed two informants from the same institution. All the informants were interviewed separately at their respective places of work in Oslo.

2.3.3 Client informants

Four clients were interviewed; three men and a woman. All informants met the selection criteria; they were ethnic minority with substance abuse problems, age and experience with treatment or rehabilitation facilities. One was in a rehabilitation center and was recruited by an elite informant who was asked to help in identifying potential interviewees. The rest were approached on the street through snowballing. One interview was conducted in the institution while the rest were conducted in a place of choice by the informants. The informants have their background from, or have ties to, Somalia, Ghana, Eritrea and Greece. All informants were over 18 years, this for the sake of consent and also for the consideration of the accumulated years of experience with health support services..

CHAPTER THREE

3.0 PRESENTATION AND ANALYSIS OF THE EMPIRICAL DATA

This chapter presents the organizing of data, transcribing of the interviews and an analyses of the interview data

3.1 Data Organization

Data collection was done through semi-structured interviews with each informant, conducted on a one-to-one basis. The informants were briefed on the use of the digital recorder; they were assured that all recordings would be kept confidential and that only the researcher would have access to them. It would not be possible to identify any of the respondents in the final report; permission was therefore obtained from each informant to audio-record the interviews. As a result, all the interviews were audio-recorded with a digital recorder. Each interview lasted approximately 45 minutes using a semi-structured interview guide. The questions were prepared with a set of themes relevant to the research question and suited to whether the respondent was –client or therapist. The semi-structured interviews were formulated to pose broad, general, and open ended questions in order to allow informants to share their views unconstrained. The questions served to guide the interview process rather than dictate it. The interviews were conducted in both English and Norwegian. I analyzed, validated and summarized the results.

3.2 Transcribing the interviews

The audio taped interviews were all transcribed into electronic text files in order to facilitate analysis. Moreover, in order to systematically organize and analyze textual data, I tried as much as possible to transcribe the audio-taped interviews right after every interview or the same day. This was in order to complement the level of the analysis and refresh my mind. Although the interviews were audio recorded, I wrote down the main aspects of the interview after each session, sometimes I took notes during the interview. The transcripts, as well as the field notes, proved useful in developing probes and follow ups or explore in more detail issues raised in the first interviews. As Kvale (1996) insists a transcript cannot ever produce a verbatim record of discourse, given the ongoing interpretive and analytical decisions that are

made. For that reason, I settled on what I transcribed because despite all best intentions, the textual data will never fully encompass all that takes place during an interview.

I decided what would be transcribed and what would be left out. Besides, I had to contend with the issue of handling confidential or sensitive information, as well as assessing the reliability and validity of transcripts. The way the transcription was done reflected the research purpose and design and was also effectively part of the data analysis. Transcribing, required precise listening, patience and careful editing, I made sure that I had enough time to transcribe the interviews accurately, and maintained tone and the integrity of the original informants' audio. In the analysis, the recorded information was returned to again and again for relistening and verifying details.

3.3 Thematic analysis of the qualitative interviews

Subsequently after transcribing the interview data, I embarked on careful perusal of the transcripts in their crude form many times. I was interested in scrutinizing the crude data for details, in order to get hold of themes and categories constructed during the interviews. Malterud (2012) thematic interview data analysis technique was used to serve this purpose. According to Malterud, knowledge is developed by interpreting and summarizing the organized empirical data co-constructed by informants and the researcher. In her systemic text condensation approach, Malterud presents four steps; using her systematic text condensation methods, I read and re-read the text and listened to the tape recordings several times. I identified some themes that I wanted the analysis to answer and wrote them down. These themes guided me through the process of analyzing and suggested how to use the findings. Through open-ended questions, I organized data by questions across all respondents and their answers in order to identify consistencies and differences. I grouped all the data from each question together. However, this grouping was also divided or guided by the two groups of informants that I had in my research (i.e. client and elite informants). I wrote down some impression as I went through the data. These impressions proved useful in understanding, coding and analyzing the data.

Themes and phrases identified were coded into coherent categories. At this stage, the empirical material was reduced to decontextualized units sorted as thematic code across individual informants. Finally, I identified patterns and connections within and between the two groups of informants and highlighted the similarities and differences. I tried to interpret and bring it all together by use of the themes and connections to explain my interpretations and attaching meaning and significance to the synthesized empirical material in order to make sure that the synthesized results still reflected the validity and wholeness of their original context (Malterud 2012).

Through the exploration and coding of the data, eleven main themes emerged '*migration*', '*acculturation*', '*culture*', '*integration*', '*social reintegration*,' '*information and understanding*', '*shame*', '*relational factors*', '*termination*' and '*resistance*'. Indeed, these broad themes will be the focus of the analysis and will help to shape the discussion and answer the research question. These key themes emanated from the answers given on each question in the question guide. However, as is evident from the extensive themes, some unanticipated responses also emerged from the interviews that also became important in the findings and the discussion.

CHAPTER FOUR

4.0 RESEARCH ISSUES AND LIMITATIONS

4.1 Ethical issues

Yin (2011) writes that one helpful way to maintain the integrity in qualitative studies is to disclose conditions that might influence the conduct of a study and the methodological conditions that might affect the study and its outcomes. He maintains that the researcher has to reveal his/her personal role and traits that might affect the study. As a result, and at the outset; I have to mention again that I am an ethnic minority working in a care facility in Oslo that takes care of young adults with housing and minor substance abuse problems. Conversely, I do not have any affiliations with the participants being studied. Nonetheless, in order to avoid the “insider” effect, I chose not to interview clients known to me within and outside the facility I work in.

The role of the researcher in this study is best exemplified by Malterud (2001) who maintains that the researcher’s background and position affects the choice of the research question, design and methods. Indeed, it affects the way the researcher concludes from the results and findings. Having said that, my demographic profile (race and ethnicity) was also an issue; I avoided assuming an advocacy position in relation to the participants and the topic being studied, though I sometimes felt that the informants viewed the interview as a form of reporting and expected me to favor certain views. Nonetheless, I observed integrity and impartiality in order to strengthen objectivity.

4.2 Formal approval of the project

The study with human participants’ required prior approval; Prior to the interviews, an application was sent to the Norwegian Social Science Data Services for approval, and it was approved. Yin (2011) asserts that the success of the research depends on people’s willingness to participate in research. In turn, involving people as research participants carries ethical obligations to respect their autonomy, minimize their risks of harm and their benefits, and treat them fairly. For these reasons, informants who accepted to be part of the study gave their voluntary informed consent to participate in the study by signing a written statement. In return, they were assured confidentiality and anonymity, and that no written or audiotaped personal information or designation was to be disclosed. Besides, the purpose of the research

was stated at the beginning of every interview, namely; that this research study was for educational purposes, and that I did not represent any office or authority.

4.3 The rigour in research method

According to Kvale (1996:229) in social science, “the concepts of generalizability, reliability and validity have reached the status of scientific methodological holy trinity that appears to be worshipped with respect by all true believers in science”. In this thesis, the same sentiments will not be altered. The following section will be dedicated to presenting an account of these fundamental scientific concepts, namely: generalizability, reliability and validity.

4.3.1 Generalizability

Yin (2011:98) insists that “generalizability is concerned with how the study can derive greater value if its findings and conclusions have implications going beyond the data collected. Generalizability is concerned with the transferability of the findings and conclusions generated in one setting, to other settings”. According to Maxwell (2002:52-53) “generalizability refers to the extent to which one can extend the account of a particular situation or population to other persons, times or setting than those directly studied. Mason (2002) writes that understanding the issues in focus will form the basis for wider resonance in similar settings. Similar to these observations, in my analysis and findings sections I tried to emphasize the importance of reflecting on the body of evidence, the ability to make critical assessments of informants’ statements and the importance of producing convincing arguments and explanations. Above all, the rigour of the analysis, the accuracy of method and clarity of the method and interpretation as accounted for in chapter two increased the adaptability and generalizability of the study’s findings.

4.3.2 Reliability

According to Kvale (1996:235) reliability “pertains to the consistency of the research findings”; that is the accuracy of the research methods and techniques, from collecting, processing, analysis and interpretations of the data by the researcher. In this study, the research samples were based on how accurate, reliable or authentic a set of data could be generated from these samples. For the purpose of reliability, the choice of informants was guided by the age of the substance user and experiences with institutional treatments. I was also concerned with particular categories or range of categories from which to generate data

which would help to develop the theory and inform the research question. However, the category was also limited to persons who are currently under treatment; in order to ensure that the information given was fresh and to avoid guess-work, selective or loss of memory, considering that substance users might have problems remembering events that happened a long time ago. On the part of the care givers, I requested informants who had both experience with ethnic minority and ethnic majority, this was for comparative purposes. Mason (2002) writes reliability is concerned with demonstrating that the researcher has not invented or misrepresented data or has been careless in data recording and analysis. To meet these requirements, I have cited direct quotes as quoted by the participants and the recorded empirical data. Furthermore, during the interview and after, the informants were reminded of the questions they had answered and asked to confirm that what the researcher had written down was what they had responded to.

4.3.3 Validity

Mason (2002:39) states that “validity means that you are observing, identifying or measuring what you say you are”. Likewise, validity is associated with operationalization of concepts, where concepts can be identified, observed or measured in the way you say they can. First, this research responded to the validity of data generation by applying more than one method to gather data, namely interviews and literature review. In addition, data was generated from two different sources, namely the substance users and the care givers. Second, validity depends on the interpretation of the data generated through a reliable research process (Mason 2002). In this case, attention was directed to the quality and rigour with which I interpreted and analyzed data from caregivers and the substance users. This helped to determine whether data from the two sources observed and identified the intended concepts.

4.4 Limitations

Since I decided to start by interviewing clients who were under treatment; I had to acquire information and permission through the institution leaders. Therefore, I opted for the strategic sampling method as stated earlier in section 2.3, in the Participant selection and profile.

In addition, the issue of confidentiality often came up. It was argued that it was up to the individual clients to decide. In some of the institutions I did not receive clear acceptance to interview, and for some institutions however, the feedback was not forthcoming at all. I accepted this because in my introductory letter, I had stated that it was voluntary to participate and that one could withdraw without stating the reason. However, when I sent my request to various institutions, also in Oslo municipality, I received positive feedback from almost all the institutions and I was even referred to professionals who fitted my description of an elite informant. However, most of the information from Oslo municipality was based on what I would call stereotypes, whenever they read my project proposal; they advised me to take contact with a worker in the municipality with a minority background who had connections with minority clients. This was strange; because for the sake of the study and its objectivity, I was not interested in activists or community mobilizers, I was interested in interviewing ordinary professionals. As a result, I ended up not interviewing any psychologist from Oslo municipality; neither did I get clients referred to me through Oslo municipality. In other (private) institutions however, my request was responded to exactly as I had expected. I was connected with clients that were potential informants. As a result, of these logistic problems, I had to change my protocol, and recruited clients where I could find them; in the streets and through the snowball sampling method. A disadvantage with this sampling method is that the informants might know each other and hence the decision about the final sample is dependent on the choice of the first individuals. All individuals may exhibit the same characteristics and traits leading to sampling bias. Still, if they belong to a particular faction or have strong biases, the study may be biased (Kumar 2011).

The sample of elite informants was professionally representative, and also quite representative of the Norwegian society, and especially of Oslo. But their beliefs and attributions may not be typical for all practicing therapists. Thus, the findings may have limited generalizability to practicing therapists, particularly those of ethnic minority who in fact are very few in this field.

CHAPTER FIVE

5.0 UNDERSTANDING SUBSTANCE ABUSE AND USERS

5.1 Theoretical perspectives

My research is based on theoretical and empirical perspectives. The various theoretical perspectives indicate the conceptual framework for understanding substance abuse. Theories will be useful for understanding concepts, phenomena and contexts. This chapter embarks on conceptualizing these theories.

5.1.1 Psychotherapy

Bohart & Tallman (1999: 105) defines psychotherapy “as a process of helping clients use their inherent capacities for change”. The client’s built-in capacities for learning are used, mobilized and supported so that the client develops new perspectives, new skills or their own creative capacity for invention.

Through the research period, the therapists maintained that they prefer to use, eclectic therapy; a style of therapy that uses techniques drawn from different schools of thought. It is a broad and flexible approach that allows the therapist to adapt to each client’s needs. However, it was common to hear therapists talk about using both cognitive therapy and psychodynamic approaches in eclectic therapy practice. This thesis contends that multicultural counseling cannot be approached through any one theory or technique of counseling. This is informed by the fact that theories of counseling and psychotherapy have failed to agree among themselves about what constitute desirable outcomes, making it difficult to determine desirable therapeutic techniques of counseling and therapy. The implicit assumption is that these techniques are imposed according to the theory and not based on client needs and values especially the minority clients (Sue & Sue 2008).

The disagreement over appropriate therapeutic techniques is increased further when the therapist and client come from different cultures. Sue & Sue (2008) contend that theories of counseling are composed of philosophical assumptions regarding the nature of man and theory of personality. A theory dictates what techniques are to be used and, implicitly in what proportions. Nonetheless, this is not to say that techniques are immaterial to psychotherapeutic outcomes; absolutely not, this thesis contends that both therapeutic

relationship and the treatment technique are synonymous with good therapeutic outcome. Indeed, Norcross (2002:13) highlights that “research has shown that an effective psychotherapist is one who employs specific methods, who offers strong relationships and who customizes both discrete methods and relationship stances to the individual and personal condition”.

5.1.2 Conceptual framework

Since 1920, there have been numerous approaches that emphasize the importance of cultural, social and historical conditions when they attempt to study human behavior; one such practice is *social constructionism*. Anderson & Goolishian (1988) defines this practice as “post-modern therapy”, where realities, meanings and understandings are socially constructed. They argue that using social constructionist perspectives with various techniques of psychotherapy in the treatment of substance abuse enriches the process and the outcome. The cornerstone in this approach is the science of interpretation and explanation; it is more about creating shared space for conversation between the participants; where the main contribution to the process of change is in the construction of a shared space, and there is mutual interaction within this space. For example, according to Newman (2004:206) “cognitive therapy introduces improved methods for understanding the patient’s non-adherence to chemical treatments and pharmacological treatments that dissuade them from collaborating optimally with their treatment programs”. Whereas, cognitive therapy can help substance users reassess and modify such perceptions, so will social constructionist approach ensure that a discourse is established between therapist and the client. Gergen & Mcnamee (1992) writes that discourse is arguably the strongest element of the working relationship through which shared space is created, within this shared space there is a sense of understanding in which meanings of one another’s thoughts, feelings, and actions are generated.

The approach in this thesis is grounded on psychotherapy as a social construction, where the discourse is constructed between the participants. However, it is important to note that while there are many available forms of psychotherapy; my approach is focused more broadly than on any specific model. I do not discuss explicitly the contents of the psychotherapy models, but rather the process and approach, drawing from a wide range of techniques. As a result, arguments in this thesis can be applicable to any form of psychotherapy that suits the needs of individual clients and one in which the therapist and patient co-construct an optimal process and outcome.

5.2 Psychotherapy as a social construction

5.2.1 Approaching therapy from a social constructionist angle

The conceptual framework for constructionist as formulated here draws primarily on the notion that reality is viewed as co-constructed in the minds of individuals in interaction with other people and through collaborative relationships. This study focuses on the process and goals in psychotherapy and how the therapist-client relationship can be used as a tool for multicultural understanding. A collaborative relationship established early in the process will help the client and the therapist co-construct interventions that are in accordance with the client's preferred outcome. In this light, therapists working in this vein emphasize the ongoing construction of meaning in everyday dialogues where discourse is established. Nonetheless, the constructions cannot be separated from the client's goals given that he is part of the constructions in a therapeutic relationship. Furthermore, without a therapeutic relationship, it will almost be impossible to apply the social constructionist approach later in therapy because constructions are constructed by persons in a relationship Gergen & Mcnamee (1992).

The constructionist approach in clinical practice can be useful to therapists who search for meanings of events and behaviors as preconditions for action; focus on the expression of people's life experiences, understandings and meanings are useful for multicultural competency and diversity. Indeed, therapy is understood as a co-creative process of personalization where therapists' and clients' co-constructed intervention, meanings and understandings of problems facing the client are influenced by cultural norms of both the client and the therapists. According to Anderson & Goolishian (1988) meanings and understandings are socially and inter-subjectively constructed, where two or more people agree or understand that they are experiencing the same event in the same way.

Anderson & Goolishian (1988) underlines that clients must and should be able to express themselves, loosen and open up because therapy is a process of broadening and saying the unsaid. The resource for change is the circle of the unexpressed, and this resource is to be found in the client and in the language. Through the therapeutic relationship, dialogue, fixed meanings and behaviors are given room, broadened, shifted and changed. Good therapeutic results depend on conversation and dialogue; it is an endeavor in which the therapist and the client are conversational partners who together engage in a shared inquiry, through social and cultural conventions.

Turner (2011) maintains that therapy allows clients to re-author their lives through reconstructing new truths and co-developments of new meanings, new realities. Indeed, the therapist does not just hear the client's story but co-creates it with the client. The therapist's role is to listen for opportunities, wonder and ask reflective questions. The therapist is not the expert on the problems in the client's life; the client is the expert, where the expertise is the ability to change. The therapist takes a "not knowing" position, but that is not to say that the therapist lacks knowledge or skills, but rather that he/she maintains respectful listening and avoids conveying preconceived set of ideas about the client. Even if, the client is expert, it does not mean that the client also can give credible explanations of what is happening and why things are not the way they should be. In reality, "clients ask for help with something they have not been able to alleviate on their own, they lack the cognitive mechanism that is required in order to solve their problems" (Anderson & Goolishian 1988:381-382). In social constructionist perspective, the clients are invited to construct other realities. Although the harsh realities of their lives are not denied as constructs of the mind, but the power given to these realities are challenged in psychotherapy. Above all, clients are helped to recognize and deconstruct self-defeating constructions. According to Turner (2011:317) "what the clients perceive to be true is challenged, clients are encouraged to question the "truth" accepted by family and the larger culture which have affected their views and held them back".

5.2.2 Research as a social construction

I interviewed substance users and therapists about their lives and experiences with each other. Kvale (1996:268) states that "a postmodern movement from knowledge as corresponding to an objective reality to knowledge as a social construction of reality involves change in emphasis from an observation of, to a conversation and interaction with, a social world". We had constructionist dialogues, where we shifted attention from the individual participants to coordinated interaction. I listened to what they had to say, their stories, their understanding and their reviews and together we discussed the treatment strategies. By approaching therapeutic practice from a constructionist point of view, i.e. from a research question through the interview, analysis and up to the writing of this thesis; I have already accepted that, as a researcher, I am engaged in social change. I am part of the process that constructs the knowledge, understanding and interpretations presented in this study. Above all, the interpretations are constructions of my understanding of the data and knowledge of issues, which comes from my reading of the literature. In the context of the interviews, it takes into account that the meeting between people is a mutual negotiation of knowledge-generation

between the researcher and the interviewee where none is superior to the other. Although, I tried to relate professionally by keeping a certain distance, I influenced by the people I interviewed, and in return, those I interviewed were also influenced by me as a researcher.

The social constructionist approach gave me access to the inner part of a field that consists of persons who are otherwise difficult to come into contact with. Through this method, I managed to create relationships that made the respondents agree to talk and participate in my research project. From this point of view, a social constructionist framework for understanding was a good starting point; it added new and wider perspectives on studies of substance abuse. Clients are social actors whose activities may contribute to social change who must be understood both biologically and socially, and as part of a social context. (Burr 1995). According to Jensen (2009) social constructionism is associated with approaches and theories of the study of humans and society. In this study, a social constructionism approach implies multicultural understanding with special emphasis on relationships, therapeutic processes, needs, contributions, dialogue and interaction.

CHAPTER SIX

6.0 ANALYSIS

This chapter presents analysis, statements, comments, reflections and thoughts of the empirical material as presented by the informants who participated in this study. In the analysis, I adopt a narrative analysis in an attempt to systematically relate the narratives to the personal experiences, feelings, beliefs of the informants and theories. This form of analysis will include excerpts from the transcripts. Throughout the analysis, attention will be given to the statements made by the informants in order to support or confirm the themes identified during the analysis of qualitative interviews (Creswell 2005). Consequently, the analysis and discussion is abundant with words and phrases that were used by the informants and their meaning in order to grasp what was exactly said. In reading more about social constructionist's texts, I considered it fair to refer to the theories as I analyzed; hence, my readings and references appear together with my research analysis.

This section explores the differences that make a difference, that result from the interaction of ethnicities in psychotherapy. A cyberneticist Bateson (1973) writes that a difference is not a thing or an event; rather, it is an abstract matter, whose essence can be shown to lie in form and pattern that can bring about change. Ethnicity constitutes a difference, perhaps the difference that makes a difference in the health delivery services, in terms of its impact on economic, political, cultural and social concerns. The reference to the concept of differences in this thesis constitutes the themes that were identified in the processed and coded data. These differences that make a difference include, '*migration*', '*social reintegration*,' '*culture*', '*acculturation*', '*shame*', '*information and understanding*', '*relational factors*,' '*termination*' and '*resistance*'. Some of the subthemes identified are discussed as subthemes under the main theme. I refined the analysis and focused on some selected parts of the conversations due to the scope of service.

6.1 Migration

The reported perceptions of informants' experience of migration and exile would seem to support the National Institute on Alcohol Abuse and Alcoholism (NIAAA) report (2003). According to the report migration leads to detachment from the known to the unknown. It is the fear of the unknown, socio-cultural and social environments that may help describe the mechanisms that partially led to substance abuse behaviour among immigrants and refugees.

Migration experience involves new realities, new ways of doing things and experiencing the world in new spaces. These realities, if not validated by the ethnic majority could result in differences of interpreting, responding to situations, conceptualizations of self-efficacy, views of the therapist and perceptions about reasonable alternatives and solutions. As an example, one elite informant expressed some concern over the migration experience;

“Client’s experience and knowledge of treatment facilities in their country of origin sometimes informs their perceived preconceptions. In reality, clients from countries that have prison-like treatment facilities of addiction and psychiatric patients do hesitate to seek help or even advise their close family members not to do so. For that reason, their experience, knowledge and migration history are important elements to factor in the process, and especially when it comes to psychotherapy resistance”.

This elite informant appeared to endorse the significant of adopting a method that is ethically and ethnically sensitive and responsive to the personal, social, economic, and political concerns associated with clients who seek help in institutional settings.

6.1.1 Failed migration expectations

Clients provided support to the argument that failed social and economic expectations can trigger substance abuse. The failure was in some cases related to fruitless search for social and economic success, failure to live to the economic expectations of their families back home, and social expectations of the ethnic majority contributed to substance abuse problems. To illustrate this, a client informant stated that:

“You know I was brought here by my grandmother; my father had already migrated to Norway and settled with a new wife. He was not helping my grandmother, and as a result, she had lost hope in her son (my father). Before she travelled back to our home country, she explained to me why she had brought me here, the reason was to educate myself and become a doctor”.

I probed further and inquired if the client still had the same ambitions,

“I thought I would do my best, but I met a lot of challenges, the new family was not friendly, my father was a taxi driver who had little time for me and my school progress. I had grown up without him, so we had no connection at all, but still he expected me to respect him 100%.” (...) “I do not think I will even become a nurse, I feel I have let down everyone; the only best thing I can do is to use drugs in order to forget. I want to disconnect from the reality. I want people to blame drugs for my failure but not me as a person”.

Another client informant stated that:

“The expectations of relatives back home may be experienced negatively. I feel that life is not good for me here; I have a family back home that could take care of me. But it is difficult to return to my country without any achievements. Relatives expect financially stable person, an educated person and driving a good car I have none of these! My life is worse than that of a poor man back home”.

These commentaries expose the tremendous expectations placed on those who manage to join their families through family re-union or even through forced migration outside their home countries. Failure to meet these expectations and utilize the opportunity means shame and frustration not only for an individual, but also for their extended family. These factors can easily lead to start, or continued stay in substance abuse behaviours.

6.1.2 Integration

The thoughts and reflections of the informants indicated that they all had a need to feel safe, integrated and supported within their community and the host community. According to the informants, the concepts of integration would appear appropriate and a desirable goal. For instance, the following statement by an elite informant,

“Many of the asylum seekers and refugees carry with them the traumatic experiences of war, torture and other violence. However, on arrival to Norway they acquire a new identity; that of an asylum seeker or refugee, this new identity, comes with some challenges, such as being excluded from the mainstream health services. This affects their physical and mental health. The need to alleviate pain and reduce frustration may therefore be the gate to the substance abuse world. Later it becomes hard to practice preventive interventions by the time client joins the mainstream society”.

I probed on what this had to do with integration. She said,

“The government has to integrate refugee treatment services into the mainstream treatment or integrate refugees in the society (municipality) where their health needs will be catered for by the respective municipalities. In addition, municipalities are required to aid asylum seekers and refugees living in their jurisdictions with employment. Employment is seen as a key component to the integration of asylum seekers and refugees”.

A client informant echoed these sentiments and said,

“Before I came to Norway, I used marijuana and “Khat” during the civil war in my country; it was involuntary given by the warlords in order to keep us awake and alert. When I came to Norway as a refugee, I wanted to quit substance abuse, but I could not join the rehabilitation program because I did not have “papers”¹ to live in Norway. I got my “papers” from the UDI 7 years after. During the 7 years, I had developed complete substance addiction behaviours. I feel that if they had understood my way of life and history, they could have helped me at once. I could not be the way I am now”.

These statements imply that there is a close relationship between weak integration and substance abuse prevention, because according to the statements of the informants the ability to integrate is seen as a predictor of success. A client informant said:

¹ Official permit to stay from the Norwegian Directorate of Immigration, (Utlendingsdirektoratet) (UDI).

“When I came to Norway, I was taken straight to class six together with the Norwegian kids; the school gauged me according to my age and not my level of understanding. I looked upon my mother to help me with some social problems both at school and outside, but she was not able to, she was not integrated and could not understand the system either. The school expected me to behave and act normal. I was victimised and excluded; I found solace in drugs and eventually I became addicted, and as a result, I dropped out of school”.

Another client said that:

“When my father brought us from Ghana to Norway, he had shown us pictures of a white lady, and he told us that he was bringing us to a Norwegian family, but when we came to Norway, our step-mother was a Ghanaian. I felt let down, at home we talked Ghanaian, but I was expected to behave as a Norwegian at school, I had two sets of rules, one at home and one at school or outside in the society. I went to a school in the asylum camp; I did not feel integrated because it was a school of the minority and contact with the Norwegian kids was lacking”.

I probed further, if it would have been better if the stepmother had been an ethnic Norwegian, he stated that it would have been better because she would have helped him integrate in the society easily. He noted that:

“My step-mother and my father spoke Ghanaian, they had little to do with the Norwegian culture, and they were not integrated either. We had African rules in the house, and all that was said in the house remained in the house. I could not share my problems with anyone, not even the school-teacher because I was afraid that this would mean trouble for me. I did not have Norwegian friends. When I was 16 years old, I joined a group of other non- Norwegian boys I started smoking hashish, and as time went by I started doing big drugs, I became addicted and could not cope up with school, I dropped out. I hope I had been integrated”.

In an interview with a client informant who had lived in Norway for over 20 years, I asked how come he is not integrated even after being in Norway for so many years. He said:

“Whenever I have a session with a new counselor, he or she gets preoccupied with how long I have lived in Norway, they wonder if I have had experience with Norwegian culture. In a way, they try to find out if I am integrated because I have lived in Norway for so many years. For me, integration is more important than the number of years one has lived in a country. I have never been to an integration programme, or introduction programme. Actually, when we came to Norway we joined an Auntie, who had lived here for so many years; this is where my problems started. The government or the municipality did not make follow-ups, I guess they thought that since my Auntie had been living here, so was she integrated too, but to the contrary she was not. She hated the Norwegian culture and way of doing things”.

What about integrating now? He said:

“You have to talk of social reintegration. I do not have a social life”. (...) “I feel that I have let down everyone, the Norwegian community that saved me from torture and my family that looked upon me. Right now I am not very much worried about integration, but how to live a normal life. But I guess if I had been integrated at early stages, I would not be sitting here talking to you about drugs problems, we would be talking business; not being integrated has ruined my life. My friends who integrated into the society are flying high, have good jobs, Norwegian wife, and they are like Norwegians”.

I asked the same question to an informant who came to Norway as a child with his parents; the answer was almost identical:

“When me and my family came to Norway, we joined one of our extended family member who came here before us, I did not go to school at once, and I guess I joined class 6 by then, it took me time to socialise. In the meantime, my family separated, and I had problems to concentrate at school, my mother could not cope with the social life of Norway; she could not understand Norwegian well as she was not well integrated, she was simply a housewife. As a result, I was sent to a Norwegian foster family, the family expected me to behave and act like a Norwegian; they thought I was well integrated. They finally they engaged the child welfare service (barnevernet)”.

I asked him about integrating now, he said:

“I am concerned about other things and not exactly integrating; time has already gone. I feel that I cannot do much about the situation as it is now”.

I asked if he felt that lack of integration had made him into who is now. He answered:

“Yes, if I had been properly integrated, in terms of social life, school life, and family life, then I could have been a better person, I was not prepared that my parents could separate; I feel that if I was integrated I could have known that divorce is a common thing in Norway. Again if, I had been in my country of origin then the situation could have been different in terms of family matters”.

Informants reported perceptions and experience suggest that minority substance users in Norway have unmet housing, educational, employment and other social needs. In many cases, these needs are evident before the substance abuse started. As a result, this group is more likely than the general population to be poorly housed, poorly educated and to be unemployed. In addition, their social and family networks may be less well developed than in the general population, thus adding to their exclusion. for instance, an elite informant said that:

“Social challenges such as bad housing, poor job prospects and reintegration are some of the challenges the therapists have to contend and orient himself/herself with and understand that drug addiction cannot be treated in isolation. It will be useless to treat substance abuse if the client does not have a place to live, he will simply go back to the streets where the environment accepts him without preconditions or prejudices or”.

6.2 Social reintegration

Through the discursive organization of the interviews, informants’ supported the findings of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) report (2012), about the purpose of social reintegration. This report maintains that the aim of social reintegration is not only to prevent or reverse the social exclusion of current and former

substance users, but also to facilitate the recovery process and help sustain the outcomes achieved during treatment. Social exclusion, according to the report is described, as the inability of an individual or group to participate fully in mainstream society, economically, politically, socially and/or culturally. EMCDDA's assessments of social exclusion correspond with the narrated experiences of the ethnic minority clients in Oslo, during and after treatment. Their experience demonstrates that the three 'pillars' of social reintegration *housing, education, and employment* are major hindrances to multicultural understanding of minority clients. A client informant described his situation like this:

"After I had been to a rehabilitation centre, I contacted The Norwegian Labour and Welfare Service (NAV) through the centre, in order to aid me with housing issues. NAV gave me a place to sleep in an institution that had a lot of "Narkomann"²; drugs and drinks were in abundance. I drank a lot and consumed drugs more than before; as a result, I was kicked out of the institution. I think the mistake came from NAV, they did not take into consideration my progress, for them I was just a drug user anyway, despite the fact that I had been to a rehabilitation centre. I was working on establishing clean relationships (...) this happened many times whenever I was on leave too. I felt that they were sending me back to the same old behaviour".

According to the EMCDDA (2012) social reintegration is any social intervention that seeks to integrate former or current problem substance users into the community, it is seen as a foundation for drug treatment and, as such it includes all those activities that aim to develop human, social, economic and institutional capital. Activities that promote social reintegration are ethical and should be integral to drug treatment. An elite informant stated that:

"Social support network is normally missing among minority substance users because of shame and the stigmatisation associated with being a substance user among the minority groups. As a result, the client after treatment is not accepted by his family or community, he/she ends up in the streets where drugs are readily available".

Another elite informant responded like this to a query about the perceptions that minorities are overrepresented in the substance abuse environment but not in the treatment facilities:

"This could not be true; these perceptions emanate from the fact that reintegration programs do not work well for minorities as they do for the majority, minorities are disadvantaged because they are in most circumstance marginalised by their community in addition to being previously marginalised by the majority, it is therefore easier to identify minorities in the substance abuse environments than the majority. They do not have houses or jobs to revert to after treatment. They are more visible in the drug abuse environments because that is their only social arenas".

In response to a probe about what should be done, he maintained that:

² *Junkies*

“For the therapist who intends to assist minority clients, he should from the outset think about social reintegration, which aims to support treatment and prevent relapse by taking a holistic view of the client with the ultimate goal of social inclusion. One should do this by engaging other stakeholders and the client in tailoring the tasks and goals of therapy from beginning to the end; housing agents, job agents and social services agents should be part of the supporting therapeutic team behind the scenes”.

These statements indicate that the counseling skills will be effective with modifications; Sue & Sue (2008) suggest that the therapist must conduct an assets search. What skills, strengths, problem solving abilities, and social supports are available to the clients?

6.3 Culture

The study poses a question of culture and how it affects the therapeutic process. I got mixed feedback both from clients and therapist on this. Therapists had the feeling that cultural differences played a role to play especially when comparing ethnic majority to ethnic minority substance users, most of them claimed that these cultural differences are due to differences in education and understandings rather than pure culture. One elite informant argued that:

“I feel that the conventional approaches of counseling are Eurocentric in nature. We apply them regardless of the culture and ethnicity of the client, and expect these approaches to have effect, but to what extent implementations of therapies tested in Eurocentric cultures apply to clients with different socio-cultural background? Why do we use generalised interventions to treat all people?” We should agree on the fact that foreigners come with unknown beliefs to us, but everyone is entitled to their own values”.

I asked her if the majority felt threatened by the values they are not familiar with? Could the problem be with the majority and not the minority? She replied,

“There is a tendency to view one’s culture, tradition and way of doing things as superior, majority are not curious and do not respect what other cultures offer that are not in the majorities culture, they do not try to sort out what can be shared that may be of value to us and them. There is a tendency to do away and demonise what we despise”.

I probed further and asked her how we should go about then; because some of the cultural practises are not appreciated in the western world and they would in fact hinder culturally sensitive interventions. She stated that:

“We should speak together with individual not collective communities and their beliefs, listen to new ideas, raise questions and ponder alternative reasoning; we have to construct a future together, when we communicate and talk with each other we construct the world we live in. May be what we construct as problems should be reconstructed as opportunities. Create new meanings through collaborative methods rather than coercive or forced assimilation”.

These are important observations that reflect our beliefs on what we perceive as problematic with the other culture and way of doing things. Her statement bears resemblance to the

observations of Gergen & Gergen (2004) that through our collaborative activities, we construct an ever-open dialogue in which there is always room for another voice, another vision and revision and further expansion in a relationship.

An elite informant while reporting on the perceptions of culture suggested that cultural differences had a role to play in substance abuse, nonetheless; he added that it was a question of difference in knowledge and understanding rather than of pure culture. He argued that:

“Non-western cultures do not have the benefit of the western knowledge, especially when it comes to diseases and treatment. Our understanding of reality of the diseases and treatment is different from theirs. There is a difference in how people think about and describe their experiences. In the western culture, we differentiate between physical pain and psychological pain while in the south, the concept of psychological pain is lacking”.

The issue of culture received divergent responses, some of the perceptions of the clients towards culture concur with Gordon (1994:173) who writes that “substance abuse is learned in a cultural context. It is an important element of some cultures that is often considered to have positive social functions”. For example, treatment orientation based on the notion that Khat is a drug of misuse in Somali is not applicable because it excludes the social and cultural aspects of chewing khat. A client stated that:

“Khat is a cultural heritage and I do not recognize it as a drug. I feel that the Norwegian justice system is imposing “illegal drug status” on Khat using the majority’s view of substance abuse. Chewing khat is a social ritual and a culture-based activity acceptable in Somali culture as is coffee drinking in Norway culture. It enhances social interactions and plays important roles in ceremonies such as weddings and family gatherings. Both men and women chew khat in social gatherings in which police, government officials, guests and families discuss important issues, listen to narratives and music”.

However, for some of the client informants, culture did not appear to be the main obstacle; on the contrary they said that therapists who chose to go the way of culture did not deliver the required results. I asked one client whether his culture or that of the therapist was a hindrance to good therapeutic process; He said:

“Not really, I do not believe it has to do with culture, a job is a job and an expert is an expert and should be able to handle his work without cultural barriers. I even do not think they should learn more about my culture in the first place, one has to get to know one another well, thereafter we can talk about culture; otherwise the expert must place my problems within the context he wants as long as it is correct. You know if he/she talks about my culture, then it can hinder him/her from understanding me as a person. First I am a client, who needs to be understood using the context of my problems, but not my culture. I want the expert to meet me with a blank ark, and we write on it together”.

When I posed the same question to another client, he stated that:

“Culture is not an issue because what the counselors do not understand about our culture is rendered problematic by this approach. Though I belong to a particular ethnic group, I remain an individual. I exist as a separate, distinct person. My personality can only change as a result of some major life event and not because of my culture”. (...) “If I use drugs, this is a behaviour that originates from personality and not from the collectiveness of a society or culture that I belong to. We are individuals that differ from one another in a number of ways even in the same family leave alone the large ethnic group”.

A client stated that:

“I do not feel that culture or my way of doing things is important; it is different from one person to the other; some people think that the culture is very important. For me culture is not that important, I do meet new challenges everyday in life, and they do not have anything to do with my culture, like housing, jobs, and so on. One has to tackle these problems as they come and not use culture to tackle or not tackle them. I feel that even Norwegians, with substance abuse problems face the same challenges as I do”.

When I met a 45 year old client informant, he indicated that in his culture, he has respect for his mother and would do anything to protect her. I asked him about how he would feel to share his substance abuse problems with his mother whom he said he respected a lot according to tradition and cultural expectation. He argued that:

“I do not know; it might go both ways, I might be sent back to Somalia, my mother will not respect that I am a grown up and an individual not the collective Somali person. She wants me to see how life is in Somali. I have not been there close to 30 years. I have heard that she has said that she will buy an air ticket. She wants me to see the other perspective of life in Somali. I have said this to my Norwegian counselors, but they get so upset, they think that it is abnormal that my mother will self-deport me to Somali; they assume that individuality is good for treatment while collectiveness is primitive. I should be my “own person” they say. The fact is that I am still bound to the collectivism that shapes my coping skills”.

The sentiments and thoughts of the clients follow Sue & Sue's (2008:201) arguments about the individualistic and collectivist cultures. The client perceived himself not just as an individual, but as an individual who is a product of his socio-cultural context. His description of the therapist's reactions indicates that therapists are more individualistic in their perspective than the clients; thus they expect the clients to yield their collectivist cultural orientation in favor individualistic. It is a way of imposing the therapist's values on the client, contrary to Sue & Sue.

“Be prepared to adopt your techniques to the cultural background of the client; communicate acceptance of and respect for the client in terms that are intelligible and meaningful within his/her cultural frame of reference, and be open to the possibility of more direct intervention in the life of the client than the traditional ethos of the counseling profession would dictate or permit” (Sue & Sue 2008:160).

An elite informant asked me if I had heard about the health care reform of 2001. I said yes, although I was not exactly sure of which reform she was talking about. However, she explained to me that in the year 2001, the Norwegian government introduced the concept Individual Plan³ through a new patients' Rights Act. The IP was established in order to enhance efficiency and quality of social and health services, and to increase patient contribution. The plan was initially intended for patients with long-term complex needs for co-ordinated health care. However, up to January 2005, when part of the substance abuse services were organised under the specialist health care, substance abusers were not entitled to IP (IP 2010).

After explaining this to me, she said:

“As a result of this regulation, treatment is established and set upon achieving goals that are tailored to the needs of the clients; it enhances respect of the client's viewpoint and perspective. IP helps to establish interventions on the basis of individual client's needs and characteristics, as opposed to treating all clients in the same manner and technique”. (...) “It incorporates the bothering question of cultural and ethnic consideration in dealing with culturally “other” clients because treatment is individually tailored to suit the client's needs, -culture and ethnicity included”.

I probed if the counselors were following the guidelines as outlined in the regulations. She stated that:

“It is up to individual specialist to abide by the law and professional ethics, besides these resolutions are statutory integrated into the specialist health service's act and within the patient's rights act; it safeguards clients in relation to confidence, respect for life, integrity and human values regardless of race or ethnicity”.

She added:

“Besides, we are now doing Client-Directed, Outcome-Informed Therapy/Practise, (klient-og resultatstyrt praksis) “KOR” as a tool to facilitate feedback from both patient and the therapist”.

6.4 Acculturation

The study experienced professional perceptions of acculturation among some of the informants interviewed. They argued in terms of acculturation and identity construction that might prove relevant to the process of multicultural understanding. Some therapists argued that the minority clients had been in Norway for a very long time and had even become

³ Popularly referred to as IP

Norwegians. Accordingly, the belief is that how clients acculturate may influence how well they become more receptive to therapeutic treatment as well as how they adapt to and navigate in the therapeutic process. By his own admission, an elite informant was indirectly referring to and praising acculturation. Yet according to Gordon (1994) therapists must at all costs avoid acculturation, a form of conflict that exists between the dominant culture and the minority cultures coexisting in the same society. One elite informant argued that:

“I do not think culture plays a role in treatment; furthermore most of his ethnic minority clients came to Norway when they were young and are good speakers of the Norwegian language”.

I probed further and asked him if being in Norway and speaking Norwegian meant that one would respond well to the therapeutic treatment strategies tainted with the influence of the dominant culture? He said:

“Kind of, language is never learned in vacuum, the client must have interacted with Norwegians; he must have acculturated himself/herself. I do not expect him/her to behave as if he/she came to Norway yesterday, we have our ways of life and doing things that is different from theirs, but when in Norway, behave and act like the host community”.

One client stated that:

“Whenever I have a session with a new counselor, he or she gets preoccupied with how long I have been living in Norway, they wonder if I have had experience with Norwegian culture, in a way they try to find out if I am assimilated because I have lived in Norway for so many years. I feel as if they are forcing me to adopt the customs and attitudes of the dominant culture that differs markedly from my own. I have the feeling that it creates mistrust and reduces the effectiveness of therapy”.

An elite informant stated that:

“I mean one must understand the role of culture, the cultural backgrounds of clients, and have sufficient information about their culture in order to understand its effect on treatment process, but this should only be used to improve treatment rather than provide arguments and justifications for resistance to treatment among the ethnic minorities. Some of my colleagues search for reasons for failure and blame culture for all that fails the ethnic minority clients”.

Regarding the statements and narratives of both the elite and client informants; acculturation is experienced as a social construction of the majority. This form of acculturation could also be termed as *biculturation* in the sense that the client would combine behaviours, beliefs, or values from two different cultures in his/her social interactions with the dominant culture. This form of acculturation may result in conflicts to the clients who reject mixing elements of their own culture with elements of the dominant culture. Therefore, acculturation is seen as problematic in this case because it fails to adequately examine the structures of the dominant

culture and its role in the social construction of social inequities facing ethnic minorities. From the statements, the therapists falls short of placing acculturation in the larger social, political and economic contexts of multicultural relationships; indeed they fail to question the role of power and marginalization of the ethnic minorities in the acculturation process. Acculturation as a social construct could dictate normalization of dominant cultures and needs while curtailing the needs of the minority. The dominant culture could systematically devalue attributions and contributions of the minority, dominate resource allocation and power over others. Therefore, for the therapist to frame the lack of responsiveness of ethnic minority to therapy as a result of lack of acculturation seems erroneous (Gordon 1994, Leach & Aten 2010).

6.5 Shame

During the interviews and from the consulted literature (Berg & Audestad 2006), it became evident that there was a need to examine the role of shame in relation to substance abuse among ethnic minorities. According to Kaufman (1996) shame is a force in culture; in some cultures it is used as a means of furthering social control and as an important socializing tool. Potter-Efron (2002:2,207) alleges that “shame is a painful sense of one’s basic defectiveness as a human being exposed to the world. It is a perceived failure of the self”. Equally, Fossum & Mason (1986) explore the clinical relationship between shame and addiction they point out that one of the most clearly identifiable aspects of shame in families is addictive behavior.

A client informant echoed Fossum’s and Mason’s (1986:126) arguments that addiction is a manifestation of the system, and becomes a supporting pillar in the system; it is much more than one single identifiable diseases. Yet, addiction presents itself as a primary, identifiable pattern in an individual. While the individual disease must be treated, the compulsiveness in the system does not vanish with one person’s individual treatment; the family is part of the user and must be part of the treatment. He stated that:

“Oslo is a small city, I may not wish to meet familiar faces in therapy due to concerns that my privacy is not guaranteed because of intra-community familiarity. The Somali community in Norway is a very tightly woven community where everybody knows everybody. I would not feel free to participate in group therapy, talk to a therapist in the presence of an interpreter from Somalia. I definitely will not share my innermost problems in such a setup”.

In the same vein, an informant who has substance abuse problem, but has never been to an institution, when asked why he does not seek help, answered straightforwardly:

"I am ashamed; I can't even mention this to my family. I am of course from Europe, but in my culture, it will be a big issue if I say that I am a drug user, uff, I will not only be kicked out of my family but the whole clan. It is shameful to the entire family and to me".

Another informant said:

"It is shame for me to speak in front of a third party; I feel that although the interpreter or family member has signed the privacy declaration, myself I have not. I feel that I do not have control of what I have just revealed; there is an imbalance of power" (...) "I feel shameful to talk about my problems in front of a person who understands my culture and a person who probably comes from my community; you know in our community everyone knows someone who knows someone".

He continued...:

"It shameful to be a psychiatric patient, it is associated with very mad people, so being a drug user is even harder and unacceptable". (...) "I will never speak to or could not contemplate talking to a therapist about my history, life problems and more so substance abuse problems in front of a family member or interpreter".

An elite informant noted that:

"Relationship should be between two persons namely; the client and the therapist, but in the presence of the interpreter, then we add a third person into the equation, and that weakens the bonding". (...) "Note language is not the only obstacle here; a third person is an obstacle too, he or she triggers shame and withholding of vital information". (...) "In the presence of the interpreter or family, I feel hard to pick up the elements of empathy, the tone, body language, silences and pauses get lost, and direct empathetic connection disappears or diminishes. It is important to note that showing or being empathetic is a crucial part of building a therapeutic relationship with a client".

Finally she gave an example of a client; she noted that a client commented and told her that, *"Norwegians understand Norwegians"*, she inquired from the client on what he meant. The client said that he felt that she (therapist) was not empathetic to him the same way she was with the Norwegian clients.

Nevertheless, an elite informant stated that:

"I do not think that shame plays a major role because after all what is important is to build a relationship and work with both shame and the drug issues simultaneously. According to my experience, after some sessions; I find that the ethnic minority gets to be at the same level with ethnic majority; it is only a matter of time and process".

However, he noted that:

"Treatment strategies, such as a group based therapy, although I do not use one, could have both positive and negative outcomes. For one, the shameful client might not feel comfortable to talk about his problems, and two he might have language problems. It is a shame not to be understood nor express oneself". (...) "Clients when on their own make rational and reasonable judgments, but when in group therapy they get influenced by external factors, are reluctant to expose their

weaknesses, are affected by the need to feel part of the group, the fear of being rejected by the group and others, as it happened before”.

6.6 Understanding of worldviews and relational factors in psychotherapy

In this section, I will try to discuss understanding perspectives. According to Leach & Aten (2010) understanding our clients brings us to a closer understanding of their experiences. The client must feel respected and understood; the therapist must first of all understand what the client understands and what he does not. The phenomenological perspective says that every man has his own worldview and reality of life. It is precisely by being able to meet and understand each person's unique experience of the world around him that we might be able to help. In the case of the cultural differences, understanding our client's perspectives can broaden our perspective enrich our way of seeing, and also maximize our capacity of empathy. Berge and Repål (2008) contend that in multicultural counseling, the difference between the therapist's and client's attribution of causes and solutions to the client's problems may be caused by differences in client's and therapist's worldviews and understandings. In treatment, there are at least two ways in which understanding perspectives can be identified through the therapist and the client.

6.6.1 The therapist's understanding

An elite informant gave reflections similar to those of Burr's (1995: 2-5) about the four main points which therapists should think of in order to be a social constructionist. “A critical approach to knowledge that is taken for granted”, “Focus on the understandings are historically and culturally specific”, understandings created through social interaction”, “understandings and social action related to each other”. She pointed out that:

“All psychological knowledge is historically and culturally important in psychotherapy; we must extend our inquiries beyond the individual into social, political and economic realms for a proper understanding of present day situation. She gave an example of a client from Surinam and stated that: Whenever there was an anniversary celebration in his country about the Independence Day. The client got psychologically disturbed; the personnel sometimes had organized the day for him to celebrate, but it appeared that he had bad memories of that day because of torture related to that particular event he had gone through in his country. I took contact with psykososialt senter for flyktninger, for guidance; and indeed it emerged that history of his country bothered him a lot. As a result, we stopped celebrating that event because it rekindled painful memories and opened old wounds”.

The elite informant's experience confirms Eriksen's (2005) arguments that by knowing something about the clients' background therapists can show that they are interested in their

situation, but they must also be aware of the possible limitations such knowledge may have, it could lead to unfortunate consequences if only statistical information and basic knowledge are used to generalize each individual. In addition, this informant knew when to consult or refer the client elsewhere, which is an important skill in multicultural counseling.

An elite informant while discussing issues of understanding cultures and experience with the minority, appeared to corroborate Eriksen's (2005) observations, when he asked: *What do I know about immigrants? What experience do we have with immigrants?, What type of knowledge is necessary to acquire in order to be able to give immigrants an equal service compared to the general population?, how can I use knowledge and understanding I already have, while I acquire new knowledge and understanding?* His response to his own questions was:

"For most of the minority clients, the extended family remains a critical safety net. While for the Norwegian client, the social welfare, public health services, kindergartens, schools, old age institutions have taken over many of the tasks from the extended family". (...) "For example Somali family is comprised of a large number of family members. It is a network of people who rely on the social capital derived from the cooperation between individuals, groups, families and within the group to ensure well-being and support for everyone. It is therefore a challenge to convince them that individual persons in a family can stand on their own without the interferences of a whole clan. For them, a person or an individual is a property of the family or clan, who may make decisions on his/her behalf. To replace this social capital with the welfare state means understanding the innermost social cultural structures of Somalis".

This elite informant's observations further confirm Eriksen's (2005) statement that to use appropriate treatment methods; one must understand relationships in the lives of others and have good insight into several aspects of their life. According to Leach & Aten (2010:125) this skill is referred to as "dynamic sizing", the ability to be flexible in fitting our knowledge of cultural factors to each client and situation.

6.6.2 Therapist's relational factors

The relationship between the therapist and the client is of fundamental importance in the approach to psychotherapy. Therapists' attitudes and interpersonal factors have also been viewed as the bedrock of effective psychotherapeutic relationships. Barry & Jodie (2002:175-285) sums up three specific therapist facilitative conditions that are necessary for change; namely **empathetic understanding** (*the extent to which the therapist is efficient in conveying his or her awareness and understanding of the client's experience in language that is harmonious to that client*), **positive regard** (*the extent to which the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being part of the*

client, he/she is caring and positive regard to the client, respecting the client as a person), and **congruence** or the extent to which the therapist is authentic and consistent, a real person, in his or her interactions with the client.

Barry & Jodie (2002) posited that these variables are necessary and sufficient conditions for facilitating change in some of the client's deepest needs and improvement of quality of service offered to clients. An elite informant when asked about the therapeutic relationship and cultural competency agreed with Barry & Jodie observations above and stated that:

"In therapy, the competency of counselors is important especially when working with minority clients. Competent therapists encounter and work with people of all nationalities and backgrounds; they should be able to use interpersonal skills and provide support that is not bound up in ethnocentricity ideologies".

Another elite informant said:

"Counselors should not be overburdened by taking a lot of ethnic minority clients, it is time and energy consuming, and it is difficult to give clients quality help required. It also affects the working moral and eventually the empathetic understanding".

According to Bohart & Tallman (1999) a therapist can be enormously valuable to clients; they provide resources, information, ideas, strategies, support, mentors and coaches. They help by discussing with clients, listening to them, helping them clarify their thoughts and strategies, and giving them feedback and information. This support is generated through the collaborative enterprise in the psychotherapeutic process. The therapists should listen empathetically be non judgmental, and allow clients space to tell their stories. Therapist and client think together, explore together and even experience together in ways that facilitate the client's problem solving creativity. The therapist offers ideas, advice, interpretations and empathetic reflections to stimulate thought; an elite informant gave an example of a client she had been following for a long time. The elite informant said:

"The client came to Norway as a single unaccompanied minor; his father had passed away during the war while the mother passed away recently. After we had established a working relationship and an alliance, I empathetically listened to the client's migration history and his family situation; we discussed how these events had affected his life and especially his substance abuse problems. He admitted that his substance abuse was related to the events he had just mentioned. I changed my perception and gave him the necessary support he required; -a week ago he came back to me and said, "You know what? I have lost everything in my life, and no one exists in my life apart from you; I believe if I die today no one will shed tears apart from you".

Through empathetic listening, the client had managed to relax and look back at his life's problems from a new perspective. He felt safe, trusted, and he began to use his own expertise. She further stated:

"Through a genuine and authentic engagement, I had managed to involve the client in the process; this had energized the therapeutic process". (...) "I felt that relationship was an "intervention" that provided an opportunity for dialogue with the client. The client gained from being understood by an empathetic therapist, warmth and regard helped him face problematic issues and found the strength to confront life in a new setup. I managed to explore and focus attention on neglected aspects of the client's life that provided solutions. In this case the neglected aspect was his migration history and family problems".

Yet another elite informant agrees with Barry & Jodie (2002:175) emphasis on congruence. First, it is the therapist's personal integration in the relationship; that he/she is freely and deeply himself/herself. Second is the capacity to communicate his or her personhood to the client as appropriate or self-disclosure. The informant narrated an experience she had with a client.

"It was not easy for me as a therapist to talk to one of my client about my family. He kept on asking me questions about my family; I felt that the client was invading my personal life. I talked to a senior psychologist about it; he informed me that this way, the client was trying to empathetically connect with me. He saw me first as a mother and wanted to know how my family was; it was a polite way of starting a conversation and greetings from his culture, his life revolved around the collective being, and he can't have it better if his family was not ok. Next, when he came for the session, I greeted him and asked him about his family, he sat down and opened himself up in a way he had never done for the past one year we had worked together. Through our conversation, that day, I listened to him; I expressed empathy and even supported his views; this way I got to know what his problems were and the cause of his substance abuse problem. He had several broken marriages, troubled childhood, and had children with different women, and none was available for him. He felt that the family was very important for him, though he had none around him".

The above therapist's narrative suggests that the client got a sense of being understood and validated.

6.6.3 The client's understanding

Henriksen (2008) argues that the client's own experience, understanding, needs and coping skills guide the therapist and help provide the best results. Indeed, all skills that clients possess make them creative problem solvers and valuable actors in finding solutions to their own problems. Skauli (2008) client assessment and view on their situation can be used to ensure the quality and efficacy of a treatment situation and help therapists learn, change and improve his competency. A client informant stated:

"I sometimes feel that the clinical practices cater for the needs of the dominant group, the needs of ordinary ethnic minority substance abuser are absent. Their concentration on medicine ignores

the real-world contexts which has made me who I am. They simply want to find diagnoses, and then give me medicine. I do not have 'pathological'⁴ issues; it is more of a social problem. I feel that the root causes of my substance abuse problems are the social problems, and if you want to cure it, you have to start with the root causes of my problems. Although, I am using drugs, drugs are not the problem here; they are in fact secondary in my line of problems”.

This above comment implies that therapists cedes the client to medicine and fail to adequately consider the personal-social histories that might provide social (as opposed to biological) explanations for patterns of human activity.

I posed a query on whether lack of knowledge and information of the existing services kept ethnic minorities from seeking help, and a client noted that:

“First, social practices, social structures and their power relations are seen as part of the system that works against ‘us’. These practices serve to create and uphold negative awareness that appear to demonize the ethnic minority client. Second the dominant culture has power, but they lack knowledge about us, they are not curious about us, on our side, we lack both power and knowledge”. (...) “Knowledge increases one’s power, by gaining knowledge about the existing resources, increases the likelihood that I will claim a share of my right and entitlements. But without knowledge then I have nothing to go after. Therefore, for me the power to claim health resources, to control or to be controlled depends upon the knowledge that I have acquired or how well I am informed”.

Anderson & Goolishian (1988) suggest that by using social constructionism as an analytical concept, the therapist’s not-knowing attitude/position is positive for relationship building and ascertains that the therapists understands the client’s world as seen from the inside. Burr (1995:7) writes that “the social constructionism regards the reciprocal interaction, where one person's liability will often respond to the expectations of the other and vice versa”. Being guided by the reciprocal relationship implies an understanding of mutual influence towards each other; it involves the recognition that the therapist has knowledge, both empirical and theoretical; but that it should be set aside until the client's knowledge and understanding perspectives have been sufficiently presented. The clients therefore have an opinion and actively co-create themselves and actively take part in the treatment process. A client said:

“Remember I am the expert; I know best where the shoe pinches most. I am an expert in my own life. But the problem is that I can’t explain why it happens the way it happens, and what I should do to solve the problem. That is the only area I need help in”. (...) “I feel that I know my problem, but the therapist don’t want to talk about my problems, they want to both define my problems and solutions without me. I should be part of the process”.

⁴ The client said, “I do not have medical issues”, but in clinical term he meant pathological issues

Further, a senior psychologist when asked whether he feels that Norwegians are more treatment friendlier than the ethnic minority, stated:

“I can’t say that Norwegians are friendlier to the treatment, I suppose they are more familiar with sickness and process; their attitude towards disease is culturally different from the perceptions of the ethnic minority. May be the difference is because one spends considerable amount of time in the beginning of the therapeutic process, explaining and convincing minorities about the problems, assigning diagnoses and the way forward. While among the ethnic majorities, they are mostly familiar with their problems, it is therefore, easy to start treatment immediately. May be that is why some professionals feel that it is difficult to work with minorities because of the time spent in establishing a relationship, defining problems and charting a path”.

6.6.4 The client’s relational factors

In a psychotherapeutic process, the experience of engagement is important; it is about meeting and connecting with another human being. This experience depends on the relational depth in the process; clients will only reveal and open up when they experience relational depth with their therapist. According to Mearns & Cooper (2005: xii) *“a relational dept is a state of profound contact and engagement between two people in which each person is fully real with the other and able to understand and value the other’s experience at a high level”.*

A successful treatment means that the client has become aware of the factors that contribute to or maintain his substance abuse problems. Skauli (2008:98) argues that no factor is more important to achieving good outcomes than the client's own contribution; he says that the help-seekers know best what kind of assistance is appropriate. According to Bohart & Tallman (1999) the primary healing agent in psychotherapy is the client; the therapist’s task is to contribute, enter into a good relationship and offer solutions based on client’s preferences where the client has a decisive influence on treatment choices, in this note a client informant noted that:

“It took me two years to tell him (therapist) what my problems were. He did not approach treatment in the right way. I was always sweating when I met him. I was neither active nor open to discuss my thoughts, and feelings. I was very defensive and hostile”.

The statement above is a testament of a weak relationship; the client’s resistance and hostility appears to have been triggered by lack of profound feelings of contact and engagement with each other’s “relational depth”. Berge and Repål (2008 insists that the client should also contribute positively to counseling by bringing in some trust, participate actively, follow up his/her own and counselors suggestions and expose himself to difficult situations.

A client informant appeared to accord Ridley's (1995:103) arguments that "the success of counseling ultimately depends upon setting and achieving goals that are tailored to the needs of clients". Goals give direction to the therapeutic process and help both therapist and client to move in a focused direction with a specific route in mind. Without goals, it is all too easy to get sidetracked or lost. Goals help specify exactly what can and cannot be achieved through counseling. Clients benefit most from counseling when goals are realistic and attainable. The client noted that:

"Whenever I met this therapist he had already predefined activities for me; he did not discuss or engage me in planning these activities. I was not an active participant in therapy. I simply sat there to receive help passively. What he said did not fit my goals nor did it make sense to me. He did not even ask me if I could do what he thought I could do. Yes, I had substance abuse problems, but my goals in relation to the other substance abusers were different".

6.7 Resistance and termination

Resistance and termination was not part of my question guide; these are issues that came up in the first interviews and kept on being mentioned several times, after the second interview I decided to include these issues in my discursive semi-structured interviews. This section will therefore present statements from informants that contain elements of resistant and termination of the therapeutic relationship. In the beginning of the interviews, I asked the clients about how many rehabilitation centers they had been to and how they had benefited or not. I wanted to gather information about their experiences with treatment facilities because this was one of my criteria for inclusion. While navigating between the various institutions and contact with therapists, I inquired why some of them had been to so many interventions and what had happened. The majority gave various reasons that were not very relevant to the study. However, the common denominator for all the clients' narratives was the manner in which resistance was perceived and how treatment was terminated. Here are some examples:

Client informant (a):

"You know I was there for the sake of my family pressure, I did not meet on time to appointments and this was conceived as not committed. I failed to show up twice, as a result, I was kicked out of the rehabilitation centre, but by then I had just started to realize how important the treatment was for me, not for family. Well, I had to go back to the same family anyway".

Client informant (b):

"I have never managed to complete a full course of therapy. I have been to four institutions; the goal of most of the institutions is to attain a substance free life, but I feel that I can also live a better life even with moderate substance 'use'⁵. My goal is not to be completely substance abuse free, but just to live a better life. My worldviews are never accepted, and whenever I lapse I am kicked out of the institution. The stock of the positive achievements though little is never appreciated, only the temporary return to old behaviors after a period of improvement is considered. I have been told many times that I am resistant to treatment, but I say I am not resistant; it is only that we have different understandings of the goals".

The statement of client informant (b) suggests that the goals and process espoused by the theories may not be those held by culturally different groups. Indeed, the thought of resistance by the therapist may suggest that the client is misunderstood, or the therapists have erred in their interpretation. Therapists are occupied by ideas about a person or situation that can lead to therapist's contributing or maintaining false perceptions about the client's resistance. Instead resistance should provide the therapist a chance to learn more about the client's needs and goals.

Client informant (c):

"This is my fifth stay in a rehabilitation center; I was kicked out from a place I have been living for the last one year, I went for a party and took drugs; it was my first lapse after a long time. I did it because of my family that has not so far appreciated my initiative to seek help, and workers who do not trust or appreciate how far I have come; I was a total "junkie" when I sought help. After I was kicked out, I went from lapse to relapse; now I have to start from Zero again".

The commentaries of the informants cited above suggest that resistance was defined entirely on the basis of the client's failure to improve and absence of therapeutic change and termination was informed by resistance and not by the goals. Yet, Beutler et al. (2002) They argue that resistance is a normal process in therapy that is designed to protect a sense of personal freedom. From this perspective, 'reactance theory'⁶ assumes that psychotherapy is a process in which the therapist exerts the forces or persuasion and social influence to change the patient's behavior, thoughts and feelings. However, human beings will naturally react negatively to perceived implied or actual threats to their free behaviors; in this case the therapist's directives may be perceived as threats to the client's freedom, hence the resistance.

⁵ The client informant referred to moderate substance abuse as "use"

⁶ A person experiences psychological reactance whenever something of his choice is taken away, limiting the range of alternatives (Beutler et al. 2002:130).

An elite informant narrated a termination process that according to her own acknowledgment appeared to advice the client consistent with the client's "life experiences and cultural values" in the termination process. This is similar to the earlier definition of multicultural competency, and she stated:

"I have been having a Somali male about 45 years of age. I have decided to terminate therapy and recommend that he moves over to early retirement benefits. We have worked on issues like rehabilitation, housing and even job. It is apparent to me that no one will ever employ him at his age and with drug addiction problems and the fact that he is from Somalia". (...) "Even finding a house for him to live in is a problem. I would not recommend termination of this nature to a Norwegian client".

CHAPTER SEVEN

7.0 DISCUSSION

Despite the very sketchy nature of our knowledge, it is possible to draw together some of the data that have been gathered, and present the rudiments of an answer to the research question posed at the beginning of this thesis,

How can better multicultural understanding of minorities, their needs and their own contributions in psychotherapy, lead to a good therapeutic process?

Multicultural understanding, needs, contributions and good therapeutic process are the key elements in the research question. These four elements in the research question will form the basis of my discussion. In trying to address the important issue of what it means to practice therapy within a social constructionist approach/framework, the study looks at the way theory has informed the research practice and the data interpretation. Throughout the discussion, the study draws attention to the problematic areas and issues identified during the research work in conjunction with the research question.

7.1 Multicultural understanding

Lack of understanding of cultural differences can create barriers between the therapist and the client, especially in the initial stages of practice. The tragedy of not being understood as a client is second only to the tragedy of being a substance user. As it was described in chapter five, therapist risks misinterpreting client behaviours, values and attitudes if he/she is not able to see through the cultural eyes of the client. According to Gergen & Mcnamee (1992) a therapist relates to the client through an understanding and constructs the interactional process he/she is involved in with the client through his/her own understanding. Both work together, utilizing their own, individual knowledge and understanding of the issues, in order to conceptualize and illuminate the client's problems and provide new context, meaning and understanding seen in the light of the historical and social-cultural context of the client.

During the interviews, elite informants repeatedly said, "African" clients chew *khat*; this was unfortunate because "Africa" is a "continent". This was to some extent an indicator that some of the interventions regard or understand ethnic groups as monolithic entities with similar

patterns of substance abuse, similar cultures, and concerns. Even minority ethnic groups that majority culture sees as similar, such as Somalis may come from different cultures also within the ethnic population. Multicultural therapists should understand that every client views his/her experience from a unique point of view. Hence, they should attend to this uniqueness both within and between cultural groups. For instance, treatment orientations based on the understanding that *khat* is an illegal substance may not yield the desired outcome among Somali clients because it excludes the *social* and *cultural* aspects of chewing *khat*. Therefore, multicultural understanding should inform the interventions to reach out to the client in a way that is respectful and welcomes learning about the client's culture rather than assessing client's needs in terms of the dominant culture's perceptions. Sue & Sue (2008) claim that a culturally competent practice is based on an understanding of clients' cultures and develops skills, knowledge, and policies for delivering effective interventions. These might include supporting the client's personal choices that are consistent with his/her cultural values.

According to the statements of the informants, it emerged that in, psychotherapy, the empathy needed to understand minority clients emerge from a communicative process that requires the coordination of client's and therapist's beliefs; in a reciprocal and consensual environment. This thesis researched the importance of therapeutic discourse, as a means of better understanding the relationship between the therapist and the client. As exemplified in section 5.1.2. Discourse is arguably the strongest element of the working relationship through which shared space is created. Within this shared space, there is a sense of understanding in which meanings of one another's thoughts, feelings, and actions are generated. This form of constructionist approach to therapy is a creative alternative for extracting meaning and understanding, socially constructed by persons in conversation. Indeed, just as clients come to therapy with their version of reality, so do therapists; But in the meantime, the constructed reality changes the therapeutic contour. The challenge is to agree or understand that they are now experiencing the same event in the same way (Gergen & Mcnamee 1992).

The process of multicultural understanding brings the therapist closer to understanding the client's experiences, a position that allows the therapist to maintain continuity with the client's worldviews, beliefs and expectations. At each stage, the therapist related to the client through understanding, modifying the relationship into an interactional process. The way of reflecting together and motivating others had effect on understanding the client's experience. The clients experienced themselves as understood and felt that they had support for their own knowledge and values. The therapist who listened to the different descriptions of what is

problematic and what could be helpful were perceived as empathetic and helpful. As exemplified in the analysis, therapists who expanded their understanding about a variety of life experience, knowledge and culture had a positive alliance with the client and facilitated good cooperation in situations where there was relational problem between therapist and client.

The clinical application of understanding, means that therapists may not be expected to know everything about every cultural group; however, rather than judging a client by the dominant society standards, the therapist's should be able to demonstrate congruence, openness, respect and empathy toward other cultures. In addition understanding, people different from you requires more than clinical guidelines and protocols. It is also necessary to supplement your intellectual development with empirical reality, socialize, work and get to know culturally diverse groups by interacting with them in order to understand their worldviews. By all means, knowledge should not be equated with expertise, but rather it should be represented by a willingness to motivate and learn about other cultures and how cultural factors may influence counseling. It appears that multicultural understanding and strategies suitable for the life values of culturally diverse clients are crucial for desirable outcomes. Therefore, this thesis takes the position that multicultural understanding is relevant to all aspects and phases of the therapeutic process.

7.2 Needs

The purpose of this section is to examine the differences that make a difference among ethnic minority in therapy. The exploration of these differences will help therapists to be more culturally sensitive to the needs of minority clients, and will increase their understanding of how minority clients utilize counseling services. Further, this section will identify whether present counseling services are meeting the needs of these groups.

Various factors appear to lead minority clients to utilize counseling services less frequently than the majority clients. The findings of this thesis provide support for the value of asking clients what help they need and then fully matching counseling to those needs in the therapeutic process. However, response to the needs also requires setting culturally relevant goals derived mainly from the client's vision of what constitutes success. NIAAA (2003) alleges that more beneficial results can be obtained if treatment is established and set on the basis of individual patient needs as opposed to treating all patients the same.

Likewise, according to the individuell plan (2010) the IP should be a tool for cooperation between the client and the service provider. Strengthening this interaction will ensure that the clients' needs are met through carefully planned and individualized interventions, structured on feedback, assessment, plans, and the possibility for the provider to provide objective perspectives on the process. From the statements of the elite informants; and as a result of the directives from Norwegian directorate of health, the IP had been introduced into substance abuse treatment services. Consequently, it was argued that IP helped in setting and achieving goals that are tailored to the needs of the client; observing respect for the client's viewpoint and perspective as envisaged in the IP statutory act.

In addition, elite informants maintained that they were doing Client-Directed, Outcome-Informed Therapy (KOR). According to Ulvestad (2007) KOR works well with the therapist's own professional understanding and approaches. Therapists trained in Norway see their worldview as rational and/or desirable; yet they may happen to lead clients in that direction. Therefore, the therapist can become a representative of the social norms, codes and rules of the majority. One of the client informant suggested that minorities may perceive psychotherapeutic health services as unrelated to their needs. She argued that, *"I sometimes feel that the clinical practices cater for the needs of the dominant group, the needs of ordinary ethnic minority substance abuser are absent"*. With little attention focused on the psychological needs of ethnic minorities in psychotherapy and the use of the conventional Eurocentric oriented counseling styles, which emphasize on pathological causes; for this reason, minorities may feel that most counseling services do not related to their needs.

In spite of the "IP" and the "KOR" being introduced with the aim of setting and achieving goals that are tailored to the needs of the client, it seems that they are not adapted to meet minority client's needs. These guidelines are not made with specifics of how diversity should be considered, leaving the therapist wondering how to include the needs of culturally diverse clients in the counseling process. According to Leach & Aten (2010:174) "therapist ascribing to such guidelines in therapy are described as "active participants" who may adhere to practice guidelines or rules in order to stay true to a theoretical frame. Hence, it is difficult for these therapists to keep the therapy process from being tainted with their own social reality".

7.3 Goals

Discussing clients needs, will not be complete without discussing goals. The findings of the study as described in section 7.2 suggest that the IP guidelines favor a western individualistic approach. Greater responsibility is placed on the individual for problems that could be symptomatic of a troubled culture. Even if, the goal is symptom removal, symptoms may be interconnected with other aspects of the client's life. As exemplified in section 6.3, Therapist must be aware of the cultural differences between the therapist and the client in setting goals; the Norwegian treatment strategies appear to favor self-reliance and individualism over collectivistic. Indeed, it is a challenge on how individualistic approach will address the treatment goals and expectations for clients who have collectivistic hierarchical and patriarchal orientation. However, for a minority client to negotiate the two worlds (collectivism & individualism) he/she must pay a considerable psychological price; it could be that ethnic minority clients with psychological vulnerabilities are more sensitive to the demands of western culture and more readily respond with behaviors such as substance abuse.

The way constructionist approach has been presented in this thesis poses a challenge to the essentialism and individualism of western psychotherapy. On the one hand, constructionism favors a replacement of the *individual* as the source of meaning with the interpersonal *relationship*; -while on the other, individual as a conscious decision maker is not so obvious. Indeed, opinions vary on who must take responsibility for goal setting in counseling. Of course, therapists are responsible because they have psychological training and expertise to determine what goals serve the best interest of clients, but clients are also responsible, they are the experts on themselves, and they are capable of determining what goals serve their own best interests (Gergen & Gergen 2004). But the client is also the person who is caught up in dysfunctional behavior, pain and shame. This unhealthy stance blinds him/her to how counseling may be most helpful. As such, this thesis shows that to maximize the assets and liabilities of the counseling goal setting should be joint undertaking. This gives clients real power and ownership to the process and goals while counselors gain early insight into ethnic minority; both construct the process, as well as the goals. Even with an "individual plan", joint construction of goals is perhaps the most important predictors for a positive outcome in the treatment process. The IP could be one way of constructing the relationship which might not be enough without collaboration of both client and therapist (Jacobsen & Gjertsen 2010).

7.4 Contributions

With regard to the psychotherapeutic approach explored in this thesis, the client is the “healing agent” in psychotherapy. It is apparent that psychotherapy is a situation where people meet for the purpose of helping one another; where the client is perceived a co-therapist, an expert on his life, and the therapist is an expert in the process, where both co-operate in order to construct solutions. As exemplified in section 6.6.4, there is evidence that clients’ understanding and contributions to the therapeutic process predict outcomes than there is for therapists’ contributions. Client factors are perhaps the most important decisive factor of therapeutic outcomes. But client’s contributions and participation depends on therapist factors as cited in section 6.6.2. The therapist acknowledges the client’s experience and worldview and opens up possibilities for change according to the client’s goals and solvable problems. In the course of the therapeutic relationship, the therapist interacts with the values, beliefs, experiences, responses and ideas of the client, and together they construct social problems and define how they should be solved (Bohart & Tallman 1999, Gergen & Mcnamee 1992).

When the issue of alliance and its relevance was brought into the debate, it was established that the most important goal was to establish a working alliance with the minority client. Clients who come into therapy and contributed positively were able to form a strong therapeutic alliance, while clients who were less able in alliance formation may have struggled to make use of therapy. Indeed, a working alliance offered the opportunity for clients and therapists to “therapize” together as equal partners and active participants of change. The stronger the therapeutic working alliance, the more likely counseling would benefit the client. Clients in such alliances expressed their emotions, including negative feelings, raised their doubts and resistances as well as their expectations, contributions, goals, and hopes for the therapy. More so, through such an arena the therapist was able to identify certain thoughts, emotions and behaviours that had impact on the client and could provide rationales for interventions and encourage the client’s feedback and approval. As a result, the clients contributed by expressing a feeling of trust triggered by the working alliance, which strengthened the alliance. This form of therapeutic bonding communicated the therapist’s willingness to hear the client’s point of view, and show that the client will have a contributory role in both process goals and outcome goals (Beck et al. 1993).

7.5 Good therapeutic process

The approach adopted in the introduction chapter, portrays therapy as a process of mutual give-and-take with therapists thinking along with the clients in dialogue. The therapist is an important partner in therapy that assists and promotes change by helping clients pull together their own resources for self-change. What therapists do is to help the client use these resources more efficiently, with support, coaching or providing important information. Through the statements of the informants, it was evident that the clients possess valuable resources, strengths and weaknesses. Indeed, through good therapeutic process, the therapist may be able to discuss these strengths and weaknesses, and identify the nature of the client's problems, the client's culture, history and resources that might limit or interfere with the effectiveness of the client's self-change process. This is exemplified by one of the elite informant who through dialogue created room and space for problem solving in the process; she gave the client room for his contributions, intelligence, generativity and initiative mainly because she genuinely trusted and respected the client as an equal contributor to the process (Bohart & Tallman 1999).

In response to the assumptions whether the majority are more treatment friendly than minority clients, the study found that treatment is a social process in which both ethnic majority and minority should be able to participate as full members on their own terms. It involves social equality for minority compared to the general population, where the minorities have equal rights, responsibilities and opportunities as other citizens. This implies that the minority should not have to give up their identity and their cultural distinctiveness or be culturally similar to the majority. Instead, it is a therapist responsibility to build a frame around the therapeutic process that provides the ability to define the problem and goals, and take effective measures and opportunity that provides for the minority client to participate on the same level as she/he does for the majority. In addition, even the choice of therapeutic approach and processes must be carefully explained to the client, why that approach was selected, and how it will help achieve the desired changes (Eriksen 2005).

CHAPTER EIGHT

8.0 DISCUSSION OF THE MAJOR FINDINGS

The main focus in chapter will cover some links between major findings, with special reference to the literature consulted, and discussion of the therapeutic relationship in a social constructionist perspective.

The research might have rediscovered the same process that has been discovered previously. Nevertheless, it appears that counselors have to build new strategies with new concepts and apply the old ones in different ways. However, when it comes to ethnic minority clients, they do have different challenges, and for that reason therapists must be willing to increase their self-awareness. Through self-awareness, therapists will understand how cultural bias may influence the way they conduct counseling sessions, assess and diagnose, conceptualize cases. Further, how they plan the interventions, create a therapeutic alliance, implement treatments and terminate therapy may also be affected. In addition, therapists' self-awareness helps clients, as it helps the therapists to consider the client's culture and how it influences who they are and perhaps why they are seeking treatment, as well as creating cultural empathy (Leach & Aten 2010).

8.1 Termination

Therapeutic relationships normally have a coherent life course and follow a predictable developmental pattern, where counseling begins with the end in mind. At each stage, the therapist must negotiate certain therapeutic tasks with the client, and find ways of incorporating culture throughout each stage of treatment; termination is one such stage. According to Ridley (1995:143) "termination is not just a significant moment in the therapeutic relationship; it is an essential part of the therapeutic process". Ideally, effective termination depends on setting goals and treatment plan early in counseling. The way in which termination is resolved is so important; it influences how well the client will be able to resolve future challenges in life. A good termination helps the client leave therapy with a greater sense of their own personal resources and ability to manage their own lives, it has a far-reaching experience for clients and holds potential to undo the achievements that have come about in therapy or strengthen the same (Teyber 1992).

Through the responses from clients and the therapists, the research found that the ending of psychotherapy, whether successful or premature termination may not have been determined by mutual agreement among the parties involved. Indeed, in successful termination, the client fully understands the decision, participates fully and assents to the reasons for ending psychotherapy, and is comfortable with the outcome (Joyce et al. 2007). An elite informant pointed out that treating clients and releasing them to the same environment will cause relapse. Here according to my understanding the informant was trying to navigate on what preparations are made prior to termination of the therapeutic process. The informant was acknowledging the unfinished business that remains, and that the client needs to finish the work that has just begun.

Nevertheless, studies on termination processes are lacking in some of the research done in Norway and especially on minority clients Berg & Audestad (2006) and Kuvoame (2005). The termination should be timely and only after the goals set in the initial phases are realized. Premature termination refers to the client's decision to end therapy contrary to the therapist's counsel and the initial agreement between client and the therapist. Indeed, the goal of multicultural counseling is to provide the client with "start-to-finish" pluralistic approach and integrating cultural issues into all aspects of counseling, including the termination phase. In light of this principle, termination ought to have been purpose driven, executed in a way that is commensurate with the goal of achieving therapeutic change and strongly enshrined to prevent the compromise of this noble purpose. It should be coupled by other factors such as housing, re-integration and follow-up services. This process will help maintain therapeutic achievements long after therapy is over. When clients end the therapy on their own initiative, the therapist must respect their independence and support their decision; and the clients must also feel that the therapist accepts their decision and that the therapist is available to help them with future crises should the need arise (Joyce et al. 2007).

The elite informants often mentioned that a short duration of treatment was not practical for minority clients. They maintained that it is well-established that members of different ethnic groups differ in the length of time they spend in the treatment; they tend to take longer time to settle down in the therapeutic process. It was argued that it was not possible for the therapist to establish a therapeutic relationship with the client. Instead, therapy ended before the process had started or the client had achieved his goals. Sometimes the therapist and the client had made considerable gains at the point when the external constraints demand termination; at other times they might have been halfway through. This unnatural termination caused by

design of and length of treatment left clients powerless and out of control. Since the argument in this study was based on making the client an active participant in his/her own treatment, termination of treatment without engaging the client in the termination process is not perceived as good therapeutic process. According to the informants, termination was done without engaging the client, sometimes because of resistance or aggressive attitude from the client. This approach denied the client the opportunity to be an active, informed participant all through the therapeutic process; -termination included.

The therapists confirmed that premature dropout among the ethnic minority was higher than that of the majority; the therapists often used confrontational methods and thereby failed to establish strong therapeutic alliances with minority clients. It was also found that therapists did not meet the client's level of understanding or adjust their approach to suit client's level in counseling; the expectations of the clients may have differed from those of the therapist and hence differing goals. Finally, it appears that therapists may not have prepared the clients on how to transfer their therapeutic gains beyond counseling, or on how to carry over the changes they made in counseling. Indeed, this was probably because of the lack of *structured or coordinated social support systems* or the *social integration* as discussed in section 8.3.

8.2 Resistance

The study found that the therapists to some extent did not honor minority client's resistance. Resistance in counseling is common; understanding the causes for resistance paves the way for appropriate response. The study experienced that minority clients had different motives for entering therapy; some were forced by cultural demands, some were forced by family or coerced by significant others while some were distressed and wanted relief from their suffering. Elite informants wondered why clients sometimes resisted the help they overtly sought on their own. The study tossed the same question back to the informants. Apparently, it was claimed that resistance was normal ambivalent behavior, but the study established that calling resistance ambivalent behavior was scratching the surface of the problem; minority clients resistant in therapy must be acknowledged. If unaddressed, these so called ambivalent behaviors may force clients to drop out of therapy prematurely.

It was reported that the majority of the ethnic minority did not show up for appointments or if they did, they came very late. It was argued that they did not show motivation or collaboration. However, it was revealed that there was a possibility that this behavior reflected

on the client's resistance to the motivational factors of entering therapy and not therapy as a process. In most cases, the therapist appeared not to have obtained a counseling contract. A counseling contract could provide the frame of references for the needs and goals of the client. It could also help in understanding when the work is in process, when it is being evaded, and when it is finished. In addition, on practical aspects counseling contracts could bring to light issues such as frequency and length of sessions, policy regarding cancellation, missed appointments and eventually the termination. Moreover, when the working relationship is strengthened by the contract, the therapist will be able to reach for the client's feedback and hence identify areas of resistance.

From the statements of the informants, it appeared that joint expectations of therapy such as commitment and effort to reach therapeutic goals were there but not agreed upon, in other words; specific, measurable, realistic, attainable goals, capable of being owned by the client were not agreed upon early in the process. These issues together with lack of structure appeared to trigger resistance among minority clients. These clients can be helped by working together in order to find some aspects of the problems they genuinely want to change; but to do this, the therapists must acknowledge resistance and respond to it in a way that restores the clients' active contribution in the treatment process. The therapists must be conscious of the feelings that underlie the clients' resistance, and be aware of the historical, social and cultural constraints of the client's life. Teyber (1992:47) claims that "resistance can and should be used to strengthen the client's commitment to therapy and to enhance the therapeutic alliance"; this can be achieved by enlisting client's help in better understanding their background and experience.

8.3 Integration and Reintegration

The study found that integration and reintegration were major determinants on how ethnic minority clients enter substance abuse and how they managed to complete treatment. Similarly, it was revealed that a majority of the minority groups with substance abuse problems were not properly integrated or did not attend the integration or introduction programs. This was partially due to lack of follow-ups from the side of the government, and partly because most of the informants interviewed claimed that they came through family reunion. Through family reunion, it was assumed that they joined families that were already integrated in the society, but the fact was that even the guardians, had not been properly integrated. This perpetuated a vicious cycle of an unintegrated group of people within and

outside the community. The study found evidence to suggest a connection between integration and development of drug addiction behaviors.

Although a comparison of majority and minority was done on a micro level, the study recognized that reintegration was also a factor that hindered the ethnic minority to seek help and feel not well understood by the helpers. The minority felt that there was little to gain after completing treatment because they lacked follow-up. They had to go back to the same environment of drug addicts in which they came from, and hence used drugs again and again; unlike the ethnic majority who to some extent were able to return to the community and families that were supportive. This was exacerbated by the housing problems, the ethnic minorities with substance abuse problems described huge problem in securing themselves accommodation/house through municipal or private house markets compared to the ethnic majority. As a result, they were forced by social circumstances back to the hospices that were breeding grounds of substance abuse and the vicious cycle of substance abuse went on and on.

On this account, some of the ethnic minority clients have lost confidence, which is probably why a majority of them are not seeking help. As narrated by the informants through their own admissions and experiences, the study found that treating addiction in isolation will not yield very helpful results, unless it is a coordinated process, between The Norwegian Labour and Welfare Service (NAV), housing agents, and potential employers. Considering that, the cause of drug addiction was found to be a combination of factors, such as lack of jobs, weak social reintegration, missing social help, and poor housing, a good follow-up after the termination of treatment is crucial. NAV could offer these follow-up services, housing, job training opportunities, and funding of recreational activities within the community.

8.4 Personal history, as well as the ethnic/culture

This thesis found that both individual ethnic/cultural factors could have an impact on the way substance abuse problems arise and how they can be solved. A number of clients seemed not to be aware of how ethnic and cultural factors influence their substance abuse behaviour and coping mechanisms. Most of the client informants claimed that cultural understanding was not an issue in the healing process; this is understandable because as, Leach & Aten (2010) point out, culture is an *invisible* but ubiquitous, and *silent* partner in counseling. Although the clients seemed not to agree, the importance of culture in psychotherapy is relevant to individuals from diverse cultural background and cannot be dismissed. Both therapist and

clients bring to counseling their cultural experiences, and counseling takes place in a multicultural setting. For instance, clients who claimed that culture is not important they still, wanted culturally competent therapists with qualities such as open-mindedness, committed to cultural competence, and active listening to how clients experienced the social world and are experienced in it. They further said that culturally competent therapists understood the client's cultural context, including their history, and how history influenced the client, the history of the individual that also included the history of the particular groups to which the client belonged. Thus, the cultural and ethnicity factors were experienced as both the source of strength and resources as well as the source of barriers to help seeking.

The assumption of this study is the importance of understanding the clients' worldview in psychotherapy rather than generalizing interventions from cultural or religious stereotypes. Still, individualization of therapy is commonly accepted as a principle. In practice therapists require an understanding of client's personal variables that are culturally significant and that influences the way the client perceives or responds to therapy. Though, it is important for the therapist to have knowledge of the values, norms, and attitudes of minority clients, he or she should also be aware of individual differences among members of ethnic minorities and be cautious about trying to tailor the counseling intervention to presumed group differences. For these reasons, it is a challenge to assume that the normal and widely practiced therapeutic process on the majority will be applicable to the ethnic minority unless it is culturally adapted.

8.5 Conclusion

This thesis has explored how better multicultural understanding of minorities, their needs and their own contributions in psychotherapy can lead to a successful therapeutic process. It has focused on interviews with the two categories of informants whose perceptions of the multicultural competencies in substance abuse treatment are seen as representative. This thesis has led to an understanding of the kinds of a multicultural understanding, needs and contributions, necessary when engaging in multicultural counseling.

Multicultural understanding gives the therapist more opportunities to achieve better therapeutic outcome. It is crucial to the success of a therapeutic process as it allows the therapist to get an insight of the client's needs, and in return create a working space where the client's contribution is called for, and reinforced by the therapist's gained cultural competence and understanding.. The concept of *co-construction* is a situation where the problems and

solutions are developed with the help of the client. Through co-construction, the therapist helps himself understand the client's needs and goals. Co-construction reduces the chance that the therapist will impose his or her own theoretical framework on the client. This approach, as exemplified in this study makes substantial and consistent contributions to the psychotherapeutic process and outcome, independent of the specific technique of psychotherapy. Accordingly, therapists recognize that no single style and technique of counseling or therapy will be appropriate for all populations and situations. Certainly, each therapeutic technique has strengths, but they may be one-dimensional; they concentrate only on cognitions, or only on feelings and behaviors. That being so, the therapists need to realize that humans are *feeling, thinking, behaving, social, cultural, spiritual* and *political* beings. This calls for a holistic thinking rather a reductionist manner when it comes to conceptualize the human condition. Hence, a therapist who is able to engage a variety of helping styles and roles is most likely to be effective in working with a diverse population.

The constructionist approach guides the therapist in adapting or tailoring counseling to the specific client needs, values, beliefs and characteristics, and thereby enhances the therapeutic process. It is out of these explorations that this study claims to have established link between multicultural understanding and good therapeutic process. The findings of this thesis, suggests that therapists must keep their own worldview, assumptions, and biases from influencing the manner in which they guide the client. Nonetheless, understanding the worldview of diverse clients means not only acquiring knowledge of cultural values and differences, but also being aware of the socio-political experiences of culturally diverse groups in a perceived monocultural society such as Norway. Hence, it is imperative for therapists to be aware of the responsibilities these varieties and diversities entail. Therapists should have multi-cultural competence, recognition, understanding and appreciating all cultural groups as well as developing skills for working with diverse groups. Last, granting the benefits and improvements provided by therapeutic strategies nurtured by social constructionism, it seems that the therapists and the client will resolve what cannot be solved by traditional biomedical approaches.

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Appendices

Appendix I. Request to participate in student research project

I am a student at the Department of Health Management and Health Economics at the University of Oslo. I am in the final year of my studies and I am now working with my thesis under the guidance of Olaf Aasland. My research project is related to multicultural issues and competency in substance abuse, treatment and therapy approaches in order to capture lessons that can be used in future interventions. How can better multicultural understanding of minorities, their needs and their own contributions in psychotherapy, lead to a good therapeutic process? The objective of this thesis is to investigate the assumptions that the needs and contributions of drug users from minority groups are not well integrated in existing treatment strategies, and that these strategies are sometimes ethnically and culturally insensitive.

This request has/is been conveyed through the institution leader. I do not know the identity of the persons invited until they agree to participate. I intend to use interview as my method of data collection. Each interview session will take less than one hour and will be recorded electronically. It is voluntary to participate and you can withdraw from the interview or the project at any time and without stating the reason. You have the right not to answer some questions and you have the right to put restrictions on how the information you give is used. All recordings will be kept confidential and only the research team will have access to them. It will not be possible to identify any of the respondents in the final report. On completion of the research project, 31.08.2013, the data will be anonymized or deleted in accordance with The Norwegian Privacy Act.

If you want to participate in this research project kindly sign the attached consent declaration form. If there are any questions regarding this research project, please do not hesitate to contact me or my supervisor. This project has been approved by the Data protection official at the Norwegian Social Science Data Services.

Kind regards

Project Leader (student)

Kamau Joseph M.
Rødtvetveien 69
0955 Oslo

Project Supervisor

Olaf Gjerløy Aasland
Professor, Institute of Health and Society
Faculty of Medicine, UiO
Postboks 1089 Blindern
0318 Oslo

Consent declaration

I have received information about the research project, “Multicultural issues and competency in substance abuse, treatment and therapy approaches” and hereby give my consent that: _____ can obtain the information that is relevant to the research project.

Date

Signature.

Appendix II. Question guides – for the elite informants

1. How is substance abuse treatment organized in Norway?
 - a). Which technique of psychotherapy do you use or apply in client treatment
 - b). In the beginning of the therapeutic session, do you explain to the clients what therapy is? Do you explain the way forward and the therapeutic process?
 - c) Describe to me whether you feel that you and the client have a common understanding of problems and goals to be achieved? Have you established a contract in the beginning of the therapeutic process in order to build and strengthen alliance with the client?
 - d). Explain to me whether you explain to the client the expected results of the therapeutic process? Explain to me how you document client's needs.
2. How can counselors in substance abuse programmes understand the culture, values and traditions of the client?
 - a). Describe to me how the family and the culture of the clients affect his relationship to therapeutic treatment and treatment process in general?
 - b). Describe to me whether you feel that culture is very important in the therapeutic process.
 - c) Describe to me how your culture and ethnicity has helped or hindered your relationship with the patient and the treatment process?
 - d). Describe to me how your attitude towards other cultures has affected the therapeutic treatment process?
 - e.) Do you feel that the Norwegian culture is friendlier to treatment than other culture? If yes! Why?
 - f.) family and Shame: It is said that clients with minority background suffer from shame in contact with treatment strategies? How do you treat shame?
3. All forms of psychotherapy depend very much on good communication and dialogue. What kind of problems do you encounter in understanding the Clients through an interpreter?
4. Think of a difficult session with a minority client; explain to me what the situation was.
5. What kind of difficulties do you experience in accessing meaning and understandings from the client due to cultural barriers and lack of culturally appropriate guidelines?
6. Considering that the interpreter is a person from the client's community and maybe he knows friends and relatives of the client, how did it affect therapeutic bonding, confidentiality and mutual relationship between you and the client?
7. How do establish a therapeutic relationship with the client, while using the interpreter? How does this affect the therapeutic process?
8. What information from the multicultural issues have you been able to use in your therapeutic process/Practice? How was it helpful?
 - a.) Explain to me if and how use of your cultural competency in substance use helped to change a client
 - b.) What kind of new knowledge and skills do you need regarding the needs, preferences, and beliefs prevalent among specific racial and cultural minority groups?

9. Explain how you ask the clients about their cultural background, and how do integrate it in the treatment process?
10. How do you address important information about client's ethnic group related to substance abuse prevention?
11. How does your understanding of people from other ethnic groups increase your understanding about the role of culture and cultural competency in substance abuse treatment and prevention?
12. Which elements of the treatment process do you think needs to be changed or added into the program? *a.) Explain how we should consider multicultural issues in the design and selection of drug treatment specific to ethnic minorities?*
13. Sometimes counselors have some beliefs, biases and stereotypes about cultural differences that affect their interactions with members of other ethnic groups. Describe whether you have at times approached ethnic minority clients with some stereotype assumptions or presuppositions that turn out to be wrong.
14. Cultural alienation is a key factor in unsatisfactory treatment outcomes for ethnic minority clients. How can we improve/include cultural diversity? How do we become culturally competent?
 - a). Explain to me how you end the therapeutic process (premature and mature terminations) describe how you explain and termination process with the client?*
 - b). Explain to me how you cope with ethnic minority resistance to therapeutic treatment?*
 - c) Explain how you include termination in the therapeutic contract with the client?*
 - d). Explain to me how you include diversity and culture in both resistance and termination of the therapeutic process?*
15. Explain how you have acquired multicultural competency. How should we make sure that school curriculums include diversity issues? Is it important?

Appendix III. Question guides – for the Client informants

1. How many rehabilitation centers they had been? *“I want to gain a picture of your experience with treatment facilities, because this is one of my criterions for including you in my study”.*
 - a). If more than two, a) then explain to me why you have been to so many rehabilitation centres.*
 - b). Please explain to me the reasons for termination?*
 - c). Have you ever completed a full course of therapy and achieved your desired goals?*
 - d). How was termination process handled? Explain to me whether you got follow-ups or referrals after termination? How has the terminations affected your relationship with therapists and your coping skills?*

- c). Does your previous experience with termination affect your re-entry into rehabilitation?
2. What do you understand about Therapy?
 - a). In the beginning of the therapeutic session, does the therapist explain to you what therapy is? Does he/she explain the way forward and the therapeutic process?
 - b). Describe to me whether you feel that you and the therapist have a common understanding of problems and goals. Have you discussed these problems in the beginning of the therapeutic process in order to build an alliance with the therapist?
 - c). Describe to me whether you feel that you and the therapist are working towards the same goals/problems simultaneously.
 - d). Explain to me whether the counselor or therapists explains to you the expected results of the therapeutic process?
2. How can counselors in substance abuse programmes better understand your culture, values and traditions?
 - a). Describe to me how religion, family and your culture affect your relationship to therapeutic treatment and treatment process in general.
 - b). Describe to me whether you feel that culture is very important in the treatment process
 - c). Describe to me how your culture and ethnicity has helped or hindered you in your treatment process?
 - d). Describe to me how your attitude to your culture has been affected by the therapeutic treatment process?
 - e). Describe to me whether culture is very important in the treatment process?
 - f). Do you feel that the Norwegian culture is friendlier to treatment than yours?
3. Language and interpreter: - Given that you are an ethnic minority, describe your problems in understanding the counselors
4. Describe the difficulties you may have accessing treatment due to language barriers and lack of culturally appropriate services and informational materials?
6. How does the interpreter affect confidentiality and therapeutic sessions? Do you feel free to talk about your problems in the presence of an interpreter? How does this affect your therapeutic relationship, bonding and process?
8. How is the knowledge and skills among the counselors regarding the needs, preferences, and beliefs prevalent among specific racial and cultural minority groups?
 - a). Please tell me, do you think that it would be easier if the counselor or therapist is from your ethnic origin?
 - c). Describe how you would feel to meet a counselor from your ethnic origin?
 - b). Do you feel that he/she would better understand your problems better than ethnic Norwegian?

9. How and why is your life history important for the counselor to know in order for him to help you?
 - a). Describe to me whether you have had the feeling that that the counselor/therapist was using a lot of professional terminologies, without listening to your basic needs and history?
10. To what extent do the counselors try to include or engage your family in the treatment process?
11. How well did the counselor address important information about your ethnic group related to substance abuse prevention?
12. How well did the counselors' understanding of people from other ethnic groups increase his understanding about the role of culture in substance abuse treatment and prevention?
13. What areas of the treatment processes do you think need to be changed or added into the program in order to cater for the ethnic minority clients?
14. Some counselors have some beliefs, biases and stereotypes about cultural differences that affect their interactions with members of other ethnic groups. Describe a situation where you felt that the counselor approached you with some stereotype assumptions or presumptions that turned out to be wrong.